

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery
 City or town..... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 1 month, 21 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution?..... 1 month, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Virginia County.....
 City or town..... Luray
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... WWI

3. (a) FULL NAME

ABBOTT, Will H.

3. (b) Social Security Number

4. Sex..... male
 5. Color or race..... W-US
 6.(a) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... Irene Abbott
 7. Birth date of deceased (mo., day, yr.)..... September 22, 1888
 6.(c) If alive, give age..... years
 8. AGE: Years..... 59 Months..... 9 Days..... 8
 If less than one day..... hrs. min.

9. Birthplace..... Virginia
 (Town, county, and state)
 10. Usual occupation..... unknown
 11. Industry or business.....
 12. Name..... ABBOTT, Charles
 13. Birthplace..... Va.
 14. Maiden name..... BAILEY, Mollie Elizabeth
 15. Birthplace..... Va.

16. Informant..... WIFE: Mrs. Irene Abbott
 Address..... Luray, Virginia
 17. burial Date thereof..... 7-3-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory..... Bethesda Chapel
 Location..... Luray, Virginia
 18. Funeral director..... Bradley Funeral Home
 Address..... Luray, Virginia
 19. 7-1 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 30 June 1948 at 1:40 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
9 May 1948 to 30 June 1948
 and that I last saw him alive on 30 June 1948

Immediate cause of death.....
Tuberculosis, Pulmonary, Rein-
fection, Active, Far-advanced.
 DURATION
unknown

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results..... confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?
 23. SIGNATURE..... W. A. DINSMORE, Jr. Lt. Cdr. MC USN
 M. D. or other
 Address..... USNH Bethesda, Md. Date signed..... 7-1-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 2 1948

BUREAU V. S.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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Evidence for change of
age and birth date shown on:

FLM No. G 116 JUL 20 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6297

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery
City or town..... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 1 day
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution?..... 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 1942 Capitol Avenue, N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war..... WWI

3. (a) FULL NAME

Herbert Thornton ANDERSON

3. (b) Social Security Number

4. Sex..... male
5. Color or race..... Col-US
6. (a) Single, married, widowed, or divorced..... married
6. (b) Name of husband or wife..... Mrs. Roberta Anderson
7. Birth date of deceased (mo., day, yr.)..... March 6, 1893
8. AGE: Years..... 55 Months..... 6 Days..... 18
If less than one day..... hrs. min.

8. Birthplace..... Virginia
(Town, county, and state)
10. Usual occupation..... Chauffeur
11. Industry or business.....
12. Name..... ANDERSON, Charles
13. Birthplace..... Va.
14. Maiden name..... Josephine ?
15. Birthplace..... unknown

16. Informant..... wife: Mrs. Roberta Anderson
Address..... 1942 Capitol Avenue, N.E., Wash., D.C.
17. burial Date thereof..... 6-30-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Arlington National
Location..... Arlington, Va.
18. Funeral director..... W. ERNEST JARVIS
Address..... 1432 U. St., NW, Washington, D.C.
19. 6-27 19 48 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 26 June 19 48 at 7:08 P
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
24 June 19 48 to 26 June 19 48
and that I last saw him alive on 26 June 19 48

Immediate cause of death..... Hypertension, arterial
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....
Autopsy results..... Cardiac Hypertrophy, arteriosclerosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?
23. SIGNATURE..... R. L. FLECK, Lt. MC USN
Address..... USNH Bethesda, Md. Date signed..... 6-27-48

55
1893
896

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JUL 1 1948
BUREAU V. S.

W. S. F.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6298

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery
 City or town..... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... B. Geo
 City or town..... Mt. Rainer
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3000 Taylor St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... WWI

3. (a) FULL NAME

ANTHONY, Harry Francis

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... W-US 6. (a) Single, married, widowed, or divorced..... widowed
 6. (b) Name of husband or wife..... Erma B. Anthony
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... February 11, 1887
 8. AGE: Years..... 61 Months..... 3 Days..... 20 If less than one day..... hrs. min.

9. Birthplace..... Washington, D. C.
 (Town, county, and state)
 10. Usual occupation..... Electrician
 11. Industry or business..... Ret. Civil Service
 12. Name..... ANTHONY, William dec.
 13. Birthplace..... Pa.
 14. Maiden name..... FLANAGAN, Mary Ellen dec.
 15. Birthplace..... Wash., D.C.

16. Informant..... son: Mr. Jack T. Anthony
 Address..... 3000 Taylor St., Mt. Rainer, Md.
 17. burial Date thereof..... 6-4-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Arlington National
 Location..... Arlington, Virginia
 18. Funeral director..... Wm. J. Nalley V. E. N.
 Address..... 3200 Rhode Island Ave., Mt. Rainer, Md.
 19. 6-1 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1 June 19 48, at 8:15A M

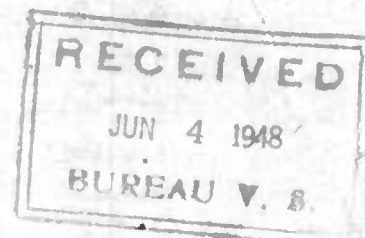
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
31 May 19 48, to 1 June 19 48
 and that I last saw him alive on 1 June 19 48

Immediate cause of death.....
Valvular Heart Disease
aortic stenosis
 DURATION..... 20 years

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results..... not permitted
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?
 23. SIGNATURE..... R. L. Fleck
R. L. FLECK, Lt. MC USN
 M. D. or other
 Address..... USNH Bethesda, Md. Date signed..... 6-1-48



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JUN 4 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6299

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery
 City or town..... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 4 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution?..... 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... D.C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 421 A St., N.E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... WWI

3. (a) FULL NAME

ASHMORE, CHARLES JOSEPH

3. (b) Social Security Number

4. Sex..... male
 5. Color or race..... W-US
 6.(a) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... Louise Ashmore
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... November 4, 1897
 8. AGE: Years..... 50 Months..... 7 Days..... 17
 If less than one day..... hrs. min.

9. Birthplace..... Pennsylvania
 (Town, county, and state)
 10. Usual occupation..... civil Service
 11. Industry or business.....
 12. Name..... ASHMORE, Thomas dec
 13. Birthplace..... Pa.
 14. Maiden name..... HALEY, Katherine dec.
 15. Birthplace..... Ireland

16. Informant..... wife: Mrs. Louise Ashmore
 Address..... 421 A St., N.E., Wash., D.C.
 17. BURIAL Date thereof..... 6-25-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... ARLINGTON NATIONAL CEMETERY
 Location..... ARLINGTON, VA.
 18. Funeral director..... CHAMBERS FUNERAL HOME A.P.
 Address..... 1400 CHAPIN ST NW WASHINGTON DC
 19. 6-21 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 21 June 19 48 at 9:50 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
17 June 19 48 to 21 June 19 48
 and that I last saw him alive on 21 June 19 48
 Immediate cause of death..... Pneumonia, Lobar
 DURATION..... 2 days
 Due to..... Hypertensive Heart Disease 3 yrs.
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?
W. F. Queen
 23. SIGNATURE..... W. F. QUEEN, Cdr. MC USN
 M. D. or other.....
 Address..... USNH Bethesda, Md. Date signed..... 6-22-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 23 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6300

CERTIFICATE OF DEATH

Reg. Dist. No. E 2K

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days 18 hrs.Hospital, institution, or street address where death occurred:
Suburban Hospital, Bethesda, Md.How long in hospital or institution? 2 days 18 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 711 Elm St.
(If rural, give LOCATION)2. (a) If veteran, name war no

3. (a) FULL NAME

John E. Benton

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Janet Benton

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

May 14, 1875

8. AGE:

Years

Months

Days

If less than one day

73118

hrs.

min.

9. Birthplace

Mainstone, Vermont
(Town, county, and state)

10. Usual occupation

Lawyer

11. Industry or business

FATHER

12. Name

Joseph H. Benton

13. Birthplace

Wareford, Vermont

MOTHER

14. Maiden name

Harriet B. Niles

15. Birthplace

Newbury, Vermont

16. Informant

wife, Janet B. Benton

Address

711 Elm St. Bethesda, Md.

17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof

June 23, 1948

Cemetery or crematory

Cedar Hill Crematory

Location

Washington, D. C.

18. Funeral director

Wm. Ransom Egan

Address

Bethesda, Maryland19. 6/23 48 John E. Jones

(Date rec'd by registrar)

19 48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1948 at 3:56 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 5 1948 to June 21 1948and that I last saw him alive on June 21 1948Immediate cause of death cardiacfailure

DURATION

1 1/2 hrs.Due to Myocarditis 6 wksDue to Arteriosclerosis 5 daysOther conditions Benign Prostatic Hypertrophy 2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations Benign Prostatic Hypertrophy -Benign prostatic hypertrophy Date of op. May 6, 1948

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE loyd E. Lewis M.D.Address 915 Thirtieth St. M. D. or otherDate signed 6/2/48Wash. D.C.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 26 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6301

Reg. Dist. No. 214

1. PLACE OF DEATH:-

County Montgomery
 City or town Garrett Park
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

31 Waverly Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Garrett Park
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 31 Waverly Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

DAVID BISSET

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

malewhitemarried6. (b) Name of husband or wife Euphemia Saunders Bisset

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 18718. AGE: Years Months Days If less than one day
76 7 1 hrs. min.9. Birthplace Dunfermen, Scotland
(Town, county, and state)10. Usual occupation Horticulturist11. Industry or business Department of Agriculture12. Name David Bisset13. Birthplace Scotland14. Maiden name Margaret Cook15. Birthplace Scotland16. Informant Albert W. Bisset, sonAddress 6963 Maple St., Takoma Park, D. C.17. Burial Date thereof June 5, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Washington, D. C.18. Funeral director Warner E. Pumphrey, Inc.Address 8434 Georgia Ave., Silver Spring, Md.19. June 4 1948 Joseph W. Schoeffel
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1948 at 11:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1947 to June 2 1948
and that I last saw him alive on June 2 1948

Immediate cause of death

Carcinomatous, general

DURATION

4 monthsDue to Carcinoma of the Rectum8 months

Due to

Other conditions Arteriosclerotic heart diseaseCongestive heart failure
(Include pregnancy within 3 months of death)?1 year

Major findings of operations

None

Date of op.

Autopsy results

0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Joseph W. Schoeffel

M.D. or other

Address 1726 E. St. N.W. Washington, D.C. Date signed 2 June '48

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JUN 9 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hrs.
Hospital, institution, or street address where death occurred:
615 W. Montgomery Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Beallsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Wm. Henry Le Roy Badner

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mollie C. Badner
6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Nov. 13 1887

8. AGE: Years 60 Months 6 Days 19 It less than one day _____ hrs. _____ min.

9. Birthplace Middleburg, Virginia
(Town, county, and state)

10. Usual occupation Capt. Montg. Co. Police Force

11. Industry or business _____

12. Name Jacob Badner

13. Birthplace Virginia

14. Maiden name Carrie Wiles

15. Birthplace Virginia

16. Informant Mrs. Le Roy Badner

Address Beallsville, Md.

17. Burial Date thereof 6-5-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Monocacy

Location Beallsville, Md.

18. Funeral director Wm. B. Hilton

Address Barnesville, Md.

19. June 4 1948 Wm. E. P. Thompson
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1948 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1945 to 2 June 48 and that I last saw him alive on 2 June 1948

Immediate cause of death Ruptured Aortic Aneurysm with hemorrhage

Due to Atherosclerosis DURATION 10 years

Due to Hypertension 20 years

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. S. Murphy M.D. M. D. or other _____

Address Rockville, Md. Date signed 2 June 48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 10 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6303

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Four days
Hospital, institution, or street address where death occurred:
207 Hudson Avenue
How long in hospital or institution? Four days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D.C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1324 Euclid St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Jennie Cook Bopp

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

8.(b) Name of husband or wife William F. Bopp
(Deceased) 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June-8-1857

8. AGE: Years 91 Months --- Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Perry, N.Y.
(Town, county, and state)

10. Usual occupation Retired- State Dept.

11. Industry or business U.S. Gov't

FATHER 12. Name Wells O. Cook
13. Birthplace N.Y.

MOTHER 14. Maiden name Fayette Williams
15. Birthplace N.Y.

16. Informant Self

Address 1324- Euclid St N.W.

17. Burial Date thereof June 21-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Nat'l. Cemetery

Location Arlington, Va.

18. Funeral director S.H. Hines Co.

Address 2901-14th St. N.W. Wash. D.C.

19. June-17-48 19 48
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 19 48 at 6:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13th 19 48 to June 15 19 48
and that I last saw her alive on June 15th 19 48

Immediate cause of death Congestive heart failure DURATION 3 wks.

Due to Chronic Myocarditis years.

Due to Arteriosclerosis years.

Other conditions Senility years.

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wallace N. Cook M.D. M.D. or other _____

Address Takoma Park, Md. Date signed 6/16/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6304

218

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Montgomery
 City or town..... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 5 DAYS
 Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, Bethesda, Md.
 How long in hospital or institution?..... 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Washington, D. C. County.....
 City or town..... (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 2810 Cortland Place, N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

BROWN, Madison

3. (b) Social Security Number

4. Sex..... M 5. Color or race..... W-US 6.(a) Single, married, widowed, or divorced..... W.
 6.(b) Name of husband or wife..... Becky Nancy Wesson
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... July 14, 1869
 8. AGE: Years..... 78 Months..... 11 Days..... 3 It less than one day..... hrs. min.

9. Birthplace..... Maryland
 (Town, county, and state)
 10. Usual occupation..... unemployed
 11. Industry or business.....
 12. Name..... BROWN, John B. dec.....
 13. Birthplace..... Pa.
 14. Maiden name..... BRYAN, Frances Kenard dec.....
 15. Birthplace..... Md.

16. Informant..... son: Mr. John B. Brown
 Address..... 2810 Cortland Pl., N.W. Washington, D. C.
 17. burial Date thereof..... 6-21-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Chesterfield
 Location..... Centerville, Md.
 18. Funeral director..... Reuben Phumphrey SRP
 Address..... 7557 Wisconsin Avenue, Bethesda, Md.
 19. 6-18- 1948
 (Date rec'd by registrar) Registrar..... Mary C. Patterson

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 17 June 19 48 at 10:55 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12 June 19 48 to 17 June 19 48
 and that I last saw him alive on 17 June 19 48
 Immediate cause of death..... Pneumonia, broncho
 Due to..... Heart disease, cerebral
 Due to..... Hypertensive Heart Disease
 Other conditions.....
 (Include pregnancy within 3 months of death)

DURATION

2 da6 daindef

Major findings of operations.....
 Date of op.....
 Autopsy results..... not permitted
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?
 23. SIGNATURE..... R. L. FLECK, Lt MC USN
 M. D. or other
USNH Bethesda, Md. 6-18-48
 Address..... Date signed.....

RECEIVED

JUN 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County MontgomeryCity or town Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)Street No. R#3

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harvey Budd.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

Married.6. (b) Name of husband or wife Mary Budd.

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 5, 18908. AGE: Years 57 Months 6 Days 5 If less than one day
hrs. min.9. Birthplace Howard Co., Maryland
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Richard Budd13. Birthplace Brinklow, Maryland14. Maiden name Maudy15. Birthplace Newport News, Virginia16. Informant Hospital record.

Address

17. Burial Date thereof June 13, 1948
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory Sandy SpringLocation Sandy Spring, Md.19. Funeral director R. L. SnoddenAddress Rockville, Md.19. 6-13 1948 Esther B. Zaver
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1948 at 9:20 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13, 1948 to June 10, 1948 and that I last saw him alive on June 10, 1948

Immediate cause of death

Pulmonary infection

DURATION

3 daysDue to Thrombo-phlebitis
& common iliac5 days

Due to

Other conditions Carcinoma of Caecum
Secondary Anemia
(Include pregnancy within 3 months of death)2 months2 monthsMajor findings of operations Carcinoma of Caecum with
Peritoneal lymph node involvement Date of op. May 29, 1948

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. H. Ligon M.D. M. D. or otherAddress Sandy Spring, Md. Date signed 6/10/48

RECEIVED STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JUN 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6306

Reg. Dist. No. 414

1. PLACE OF DEATH:

County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
631 Richie Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 631 Richie Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles W. Burch

3. (b) Social Security Number

214-03-8111

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Lula W.

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

April 19, 1873

8. AGE:

Years

Months

Days

If less than one day

7528

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

Francis Burch

13. Birthplace

Maryland

14. Maiden name

Harrett P. Newton

15. Birthplace

Virginia

16. Informant

Mrs Lula W. Burch

Address

631 Richie Ave.

17.

Burial

Date thereof

June 30, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Monocacy Cemetery

Location

Beallsville, Mont. Co., Md.

18. Funeral director

Warner E. Pumphrey, Inc.

Address

8434 Georgia Ave, Silver Spring, Md.

19.

June 29 1948

(Date rec'd by registrar)

Josephine Schaffer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

27 JUNE, 1948 at 3:35P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

25 JUNE, 1948, to 27 JUNE, 1948and that I last saw him alive on 27 JUNE, 1948

Immediate cause of death

CONGESTIVE HEART FAILURE

DURATION

Due to

ARTERIOSCLEROSIS &
HYPERTENSION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

NONE

Date of op.

Autopsy results

NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. Marshall Leavitt, Jr. M.D.

M. or other

Address

8648 GEORGIA AVE.

Date signed

27 JUNE 48SILVER SPRING, MD.

RECEIVED

JUL 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County... Montgomery
 City or town... Olney
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9
 Hospital, institution, or street address where death occurred:
Montgomery Co. General Hospital
 How long in hospital or institution? 9

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Montgomery
 City or town... Ellicott Spring RT #1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Benifant Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

JOHN William BURRISS

3. (b) Social Security Number

4. Sex M 5. Color or race Wh 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

8.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) May 7, 1880
 8. AGE: Years 68 Months 1 Days 22 If less than one day hrs. min.

9. Birthplace Layhill, Montgomery, Md.
 (Town, county, and state)
 10. Usual occupation LABORER

11. Industry or business

12. Name John Burris
 13. Birthplace Montgomery Co. Maryland
 14. Maiden name Elizabeth Burris
 15. Birthplace Montgomery Co. Maryland

16. Informant Earl Rabey
 Address Silver Spring RT #1

17. Burial Date thereof July 2, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Lay Hill Methodist Church
 Location Lay Hill, Md.

18. Funeral director Waxner E. Pumphrey, Inc.
 Address Silver Spring, Md.

19. July 1 1948 Esther B. Lawler
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1948 at 5:25 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22, 1948 to June 29, 1948
 and that I last saw him alive on June 29, 1948

Immediate cause of death Uremia DURATION 8 weeks
 Due to Arteriosclerosis nephrosclerosis 7 years
 Due to Hypertensive Cardiac Vascular Disease 4 years
 Other conditions Recent hemorrhage from left middle cerebral artery 1 month
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE C. H. Egan per R. P. W. M. D. or other
 Address Silver Spring, Md. Date signed 6/29/48

RECEIVED

JUL 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month, 6 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 1 month, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 220 E St., N.E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WWI

3. (a) FULL NAME

BURTON, Robert Louis

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Daisy Burton
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 13, 1896
 8. AGE: Years 51 Months 11 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
 (Town, county, and state)

10. Usual occupation Painter

11. Industry or business _____

FATHER 12. Name BURTON, William Arthur dec.
 13. Birthplace Va.

MOTHER 14. Maiden name KARNES, Lena Bell dec.
 15. Birthplace Va.

16. Informant wife: Mrs. Daisy Burton
 Address 220 E St., N.E., Wash., D.C.

17. burial Date thereof 6-22-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.

18. Funeral director Lee Funeral Home
 Address 4th & Mass. Ave., N.E., Washington D.C.

19. 6-19-48 19 _____
 (Date rec'd by registrar) Registrar Mary C. Patterson

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 June 19 48 at 5:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 May 19 48 to 19 June 19 48
 and that I last saw him alive on 19 June 19 48

Immediate cause of death Uremia

DURATION terminal

Due to transfusion Reaction

Due to transfusion Reaction

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Subacute cholecystitis

2 choleliths Date of op. 6-15-48

Autopsy results same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury T.R.N. Shelley Injured at work? _____

23. SIGNATURE R. N. SHELLEY, Cdr. MC USN

M. D. or other _____

Address USNH Bethesda, Md. Date signed 6-19-48

RECEIVED

JUN 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6309

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 months
 Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
 How long in hospital or institution? 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State District of Columbia County -
 City or town Washington D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4701 Penn. Ave N.W. Apt 301
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Mrs. Nonnie Calvert

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Charles H. Calvert
 6.(c) If alive, give age 48 years
 7. Birth date of deceased (mo., day, yr.) 7-15-1857
 8. AGE: Years 90 Months 10 Days 16 If less than one day hrs. min.
 9. Birthplace Washington, D.C.
 (Town, county, and state)
 10. Usual occupation none
 11. Industry or business

12. Name Joseph P. Newman
 13. Birthplace Philadelphia, Penn.
 14. Maiden name Anne J. Marks
 15. Birthplace Virginia

16. Informant Mrs. Ethel Hess
 Address 1535 Locust Rd. N.W. Wash. D.C.

17. Burial Date thereof June 2-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cedar Hill Cemetery
 Location Prince Georges County

18. Funeral director D. H. Jones Co.
 Address 2901-14 14th St. N.W.

19. June 1 19 48
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-1 19 48 at 5:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 19 48 to June 1 19 48
 and that I last saw him alive on May 31 19 48

Immediate cause of death Myocardial infarction
arteriosclerosis

Due to cardiac failure
in action

Other conditions None
 (Include pregnancy within 3 months of death)

Major findings of operations 0
 Date of op. 0

Autopsy results 0
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide 0 Date of 0

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE B. H. Shobler Jr.
500 Woodward Ave N.W. M. D. or other
 Address 500 Woodward Ave N.W. Date signed 6/1/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County MONTGOMERY
 City or town ROCKVILLE RFD 4
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? TWO YEARS

Hospital, institution, or street address where death occurred:

172 CARROLTON ROAD

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY
 City or town ROCKVILLE 4
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 172 CARROLTON ROAD
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

CARRIE WESTNEDGECARNEY

3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

MAURICE P. CARNEYDECEASED

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

FEBRUARY 8, 1869

8. AGE:

Years

79

Months

4

Days

22

If less than one day

hrs.

min.

9. Birthplace

ROMENEW YORK

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

FATHER

12. Name

THOMAS WESTNEDGE

13. Birthplace

ENGLAND

MOTHER

14. Maiden name

MARY BURCHNELL

15. Birthplace

ENGLAND

16. Informant

MRS JAMES C. DULIN, JR.

Address

MANOR CLUB ESTATES, ROCKVILLE 4

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

July 1, 1948

Cemetery or crematory

OAK HILL BATTLE CREEK MICH

Location

18. Funeral director

Joseph F. Birch's Sons

Address

3034 N. St. N.W., Wash. D.C.

19. Date rec'd by registrar

June 30, 1948

Registrar

Joseph F. Birch's Sons

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 30th

19

48

at

9 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1st 1948 to 6-30-48and that I last saw him alive on June 27-48Immediate cause of death Exhaustion Cardiacfailure

DURATION

Due to

Carcinoma, Stomachabout

Due to

Liver & lungone year

Due to

Carcinoma of Tox

Other conditions

Cause still unknown!

Other conditions

unimportant

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

When did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. F. Moulden, M.D.

Address

3401 - Lowell St. N.W. D.C.

Date signed

6-30-48

RECEIVED

JUL 7 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6311

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Birth
Hospital, institution, or street address where death occurred:
Suburban Hospital Old Geo Rd.
How long in hospital or institution? Birth

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4602 - Chase Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war none

3. (a) FULL NAME

Adrien Thomas Caron Jr

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife None
7. Birth date of deceased (mo., day, yr.) June 8 - 1948
6. (c) If alive, give age - years
8. AGE: Years - Months - Days 9 If less than one day 34 hrs. 34 min.

9. Birthplace Bethesda, Montgomery, Maryland.
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name Adrien Thomas Caron Jr.

13. Birthplace Fort Kent, Maine

14. Maiden name Elizabeth June Sackett

15. Birthplace Washington, DC

16. Informant Elizabeth June Caron

Address 4602 Chase Ave.

17. Burial Date thereof June 11, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Suitland, Maryland

18. Funeral director Wm. Hansen Humphrey

Address Bethesda, Maryland

19. 6/10/48 Registrar Wm E Jones

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1948 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jun 8 to Jun 9 19 48

and that I last saw him alive on Jun 8 19 48

Immediate cause of death Permanent (C.H. Mott)

Due to Permanent (C.H. Mott)

Due to Permanent (C.H. Mott)

Other conditions Permanent (C.H. Mott)

(Include pregnancy within 3 months of death)

Major findings of operations Permanent (C.H. Mott)

Date of op. Permanent (C.H. Mott)

Autopsy results Permanent (C.H. Mott)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of Permanent (C.H. Mott)

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) (City or town) (County) (State)

Means of injury Permanent (C.H. Mott) Injured at work?

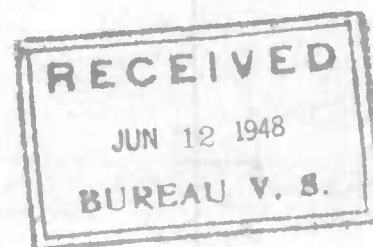
23. SIGNATURE Wm E Jones M. D. or other

Address 4602 Chase Ave Date signed 6/9/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



00.0432

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

6312

93d

1. PLACE OF DEATH:

County Montgomery
City or town Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No. 932 Phila Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ELINORE CHINE CHAPMAN

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE SEPERATED.

6. (b) Name of husband or wife Louie Chapman

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 73 Months Days If less than one day hrs. min.

9. Birthplace Iowa.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name William Chine

13. Birthplace Virginia

14. Maiden name

15. Birthplace Nebraska

16. Informant Louie Bates

Address 932. Phila Ave Silver Springs

17. Removed Date thereof June 23-1948
(Burial or cremation, or other disposition) (Month) (Year)

Cemetery or crematory Cedar Hill Cemetery

Location on Res Co. rd

18. Funeral director W.W. Chambers Co

Address 1400. Chapin St N.W.

19. June 23 1948 Joseph R. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1948 at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1947 to June 23 1948
and that I last saw h. er alive on June 22 1948

Immediate cause of death Acute Congestive Heart Failure DURATION 15 Min.

Due to Coronary Arteriosclerosis Several Years

Due to

Other conditions Generalized Arteriosclerosis " " Degenerative Arthritis " "

(Include pregnancy within 8 months of death)

Major findings of operations Not done Date of op.

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L.B. Snow L.B. Snow M.D.
M. D. or other

Address Silver Spring, Maryland Date signed 6-23-48

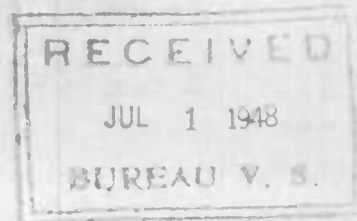
MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete age is especially important. Physicians: please write the causes of death clearly and legibly.

1948
73
1875



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6313

186a

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Lewis
 City or town Fulton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW2 ✓

3. (a) FULL NAME

CISSEL, Philip Loyd

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 8.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) December 31, 1913
 8. AGE: Years 34 Months 5 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation unknown
 11. Industry or business _____

12. Name CISSEL, Brown
 13. Birthplace unknown
 14. Maiden name DAVIS, Marion dec
 15. Birthplace Md.

16. Informant brother: Mr. Marion Cissel
 Address Fulton, Maryland
 17. burial Date thereof 6-29-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National
 Location Arlington, Va.
 18. Funeral director W. W. Chambers A.P.
 Address 1400 Chapin St. N.W., Washington, D.C.

19. 6-26 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 June 19 48 at 1:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 June 19 48 to 25 June 19 48
 and that I last saw him alive on 25 June 19 48

Immediate cause of death _____
Intracranial Injury
Epileptiform seizure
 Due to Psychosis, Unclassified

DURATION
3 days

Due to _____
 Due to _____
 Other conditions Hypertensive Heart Failure
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____
 Autopsy results confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 6-22-48
 Accident, suicide, or homicide accident Date of _____
 Where did injury occur? Washington, D. C. (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Baseball park
 Means of injury fell during epileptiform seizure Injured at work? ---

23. SIGNATURE R. V. BERRY, LCDR MC USN
 M. D. or other _____
 Address USNH Bethesda, Md. Date signed 6-26-48

RECEIVED

JUL 1 1948

BUREAU V. 8

A15

RECEIVED

JUN 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6315

Reg. Dist. No. 112

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hrs
 Hospital, institution, or street address where death occurred: Suburban Hosp.
8600 Old George Town Rd., Bethesda Md.

How long in hospital or institution? 4 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Chevy Chase
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 106 E. Kirk St.
 (If rural, give LOCATION)

2. (a) If veteran, name war No

3. (a) FULL NAME

Mrs Dorothy Danischefsky Danischefsky

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W6. (b) Name of husband or wife Roy W. Danischefsky7. Birth date of deceased (mo., day, yr.) Nov. 9, 1900 6. (c) If alive, give age _____ years8. AGE: Years 47 Months 7 Day 22 If less than one day _____ hr. _____ min.9. Birthplace Milwaukee Wisconsin
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Adam Gross13. Birthplace Germany14. Maiden name Clara McCully15. Birthplace ?16. Informant HusbandAddress 106 East Kirk St. Chevy Chase, Md17. Burial-Transit Burial-Transit Date thereof June 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Milwaukee, WisconsinLocation Milwaukee, Wisconsin18. Funeral director Wm Renter HumphreyAddress Bethesda, Maryland19. 6/3 19 48 Wm Egles Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1948 at 10:30 M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1, 1948 to June 1, 1948and that I last saw him/her alive on June 1, 1948Immediate cause of death Coronary occlusion DURATION 6 hrs.Due to Coronary artery disease ? 3 yrs.Dus to 0Other conditions 0

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. H. Warner M.D. M. D. or other _____Address 7302 Conn. Ave. Date signed 6/1/48

RECEIVED

JUN 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery
 City or town..... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 1 month, 22 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution?..... 1 month, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Va. County.....
 City or town..... Mt. Jackson
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... WWII

3. (a) FULL NAME

DELLINGER, Walter Herman

3. (b) Social Security Number

4. Sex..... male
 5. Color or race..... W-US
 6.(a) Single, married, widowed, or divorced..... single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... November 1, 1918
 8. AGE: Years..... 29 Months..... 7 Days..... 28 If less than one day..... hrs. min.

9. Birthplace..... Virginia
 (Town, county, and state)
 10. Usual occupation..... Civil Service
 11. Industry or business.....
 12. Name..... DELLINGER, Charles
 13. Birthplace..... Va.
 14. Maiden name..... Hildred ?
 15. Birthplace..... Va.

16. Informant..... father: Mr. Charles H. Dellinger
 Address..... Mt. Jackson, Va.

17. burial Date thereof..... 7-1-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Conicville Church
 Location..... Conicville, Va.

18. Funeral director..... Dellinger & Sons V.L.D.
 Address..... Woodstock, Va.

19. 6-29- 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 29 June 19 48 at 1:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
7 May 19 48 to 29 June 19 48
 and that I last saw him alive on 29 June 19 48

Immediate cause of death..... Pneumonia, Broncho
 DURATION..... 2 days

Due to..... Hodgkins Disease
 DURATION..... 15 M.O.

Due to.....
 DURATION.....

Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... W. F. Queen M. D. or other

Address..... USNH Bethesda, Md. Date signed..... 6-29-48

RECEIVED
JUL 1 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6317

Reg. Dist. No. 214

1. PLACE OF DEATH

County Montgomery
 City or town Manassas Park, Rockville, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montg
 City or town Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Manassas Park
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Winfield Scott Day

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

m w widowed

6. (b) Name of husband or wife. Lucy H. Day - Deceased7. Birth date of deceased (mo., day, yr.) Oct 27 1870

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

77 7 12 hrs. min.

9. Birthplace (Town, county, and state)

Iowa10. Usual occupation retired11. Industry or business government clerk12. Name Chas. W. Day13. Birthplace N.Y.14. Maiden name Harriet Suppe15. Birthplace New York State16. Informant Harriet Day 3rd childAddress Barcroft Va17. Burial Date thereof 6-12-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Chestnut Grove CemeteryLocation Herndon Virginia18. Funeral director The S. H. Hines CoAddress 2901 - 14th St N.W.19. June 9 1948 Josephine Schaeff Registrar

(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept med exam caseand that I last saw him alive on 19

Immediate cause of death

Coronary occlusion

DURATION

Found dead at home

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Frank J. Brorshart M.D.

M. D. or other

Address Washington Md Date signed 6-9-48

RECEIVED

JUN 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6318

Reg. Dist. No. 217

1. PLACE OF DEATH:

County MontgomeryCity or town Carroll Station
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Montgomery County General HospitalHow long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Brownsville
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

DAVID J EVELY

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 19 - 1877

6. (c) If alive, give age

— years

8. AGE:

Years

Months

Days

If less than one day

69228— hrs.— min.9. Birthplace Laytonville, Montgomery, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial
(Burial, cremation, or removal. Which?)Date thence June 17 - 1948
(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19. 6/18/48
(Date rec'd by registrar)19. 48Gertrude C. Lander
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1948 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 8, Nov. 1, 1948 to June 15, 1948and that I last saw him alive on June 15, 1948

Immediate cause of death

Cyclorophthalmos

DURATION

4 days

Due to

Due to

Other conditions

Diabetes Mellitus 8 years
Generalized Colicis relin 2 years
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Sandy Spring, Md. M. D. of 6/15/48
Address Sandy Spring, Md. Date signed 6/15/48

UNITED STATES DEPARTMENT OF HEALTH

CENTRAL BUREAU OF HEALTH

ADMINISTRATIVE SECTION

RECEIVED

JUN 30 1948

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6319

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County -
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1536 D St N.E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

Mary Jane Fearson

3. (b) Social Security Number

4. Sex female 5. Color or race Cauc. 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Howard F. Fearson
 7. Birth date of deceased (mo., day, yr.) December 31, 1899
 6.(c) If alive, give age 49 years
 8. AGE: Years 54 Months 7 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D.C.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business -

FATHER 12. Name Thomas McKean
 13. Birthplace Ireland
 MOTHER 14. Maiden name Elizabeth Brown
 15. Birthplace Washington, D.C.

16. Informant Mr. Howard F. Fearson
 Address 1536 D St N.E., Wash. D.C.

17. Burial Date thereof June 23, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Arlington National Cemetery
 Location Arlington, Va.

18. Funeral director W. W. Chambers
 Address 517-11 St. S.E.

19. June 19 19 48 Josephine Schaeffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 19 48 at 7:05 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-2 19 47 to 6-19 19 48
 and that I last saw him alive on 6-19 19 48

Immediate cause of death Subarachnoid hemorrhage DURATION Sudden
(massive)
 Due to Nephrosclerosis 10 yrs
 Due to secondary hypertension 5 yrs
 Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results No
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Josephine Schaeffer M. D. or other _____
8252 R Date signed 6-19-48
 Address _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 417 Buchanan St., N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WWI

3. (a) FULL NAME

FEMIG, John

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mrs. Gertrude L. Femig

7. Birth date of deceased (mo., day, yr.) August 4, 1888
 6.(c) If alive, give age _____ years

8. AGE: Years 59 Months 10 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Austria
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name FEMIG, John dec13. Birthplace Austria14. Maiden name GRAU, Sophie dec.15. Birthplace Austria16. Informant wife: Mrs. Gertrude L. FemigAddress 417 Buchanan St., N.W., Wash., D.C.

17. burial Date thereof 6-14-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director W. W. CHAMBERSAddress 1400 Chapin St., N.W., Wash., D.C.

19. 6-11 18 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 June 19 48 at 8:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
8 June 19 48, to 11 June 19 48

and that I last saw him alive on 11 June 19 48

Immediate cause of death Carcinoma, Metastatic, Pulmonary Hypernephroma
 DURATION 1 yr.
2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. R. COOPER, Jr. MC USNAddress USNH Bethesda, Md. Date signed 6-11-48

RECEIVED

JUN 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6321

Reg. Dist. No. 214

1. PLACE OF DEATH:

County... Montgomery
 City or town... Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 months
 Hospital, institution, or street address where death occurred:
10,000 Georgia Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... County...
 City or town... Washington, D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7510 17th St. N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Blanche Irene Finch

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 18, 1866 6. (c) If alive, give age years

8. AGE: Years 81 Months 10 Days 25 If less than one day hrs. min.

9. Birthplace... Washington, D.C.
 (Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

12. Name... John Henry Howlett13. Birthplace... Lowestoft, England14. Maiden name... Jane Elizabeth Pywell15. Birthplace... Baltimore, Md.16. Informant... Dr. H. H. HowlettAddress... 928 Sligo Ave. Silver Spring

17. Burial Date thereof June 15, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Rock Creek CemeteryLocation... Washington, D. C.18. Funeral director... Warner E. Pumphrey, Inc.Address... 8434 Ga. Ave., Silver Spring, Md.

19. June 14 19 48 Josephine M. Schaeffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... June 13 19 48 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 19 47 to June 13 19 48
 and that I last saw him alive on June 12 19 48

Immediate cause of death Chronic Myocarditis DURATION 2 months

Due to Chronic Myocarditis 1 year

Due to

Other conditions Acute Pyelitis 1 month

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Howard H. Howlett M.D.

Address... 928 Sligo Ave. Silver Spring, Md. Date signed June 13, 1948

RECEIVED

JUN 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6329

200a

Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 min.
 Hospital, institution, or street address where death occurred: Suburban Hospital
6600 Old Georgetown Rd. Bethesda Md.
 How long in hospital or institution? 10 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Saithersburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr Elmer Franklin Fletcher

3. (b) Social Security Number

4. Sex m 5. Color or race W 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Blanche

7. Birth date of deceased (mo., day, yr.) June 15, 1900 6. (c) If alive, give age _____ years

8. AGE: Years 48 Months _____ Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Hancock Maryland
 (Town, county, and state)

10. Usual occupation Attendant for animals at naval med.

11. Industry or business

12. Name Lyman Cobb Fletcher

13. Birthplace Fulton Co Pennsylvania

14. Maiden name Sarah Ellen Fletcher

15. Birthplace Fulton Co Pennsylvania

16. Informant Daughter, Mrs Walter Brown

Address Colombo Rd -

17. Burial Date thereof 6/29/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fourth Oak Cemetery

Location Saithersburg Md.

18. Funeral director E. B. Fisher

Address Saithersburg Md.

19. June 29 1948 Alma G. Cooke
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27 19 48 at 12 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 19 48 to June 27 19 48

and that I last saw him alive on June 27 19 48

Immediate cause of death _____

Acute Cardiac Failure 16 hrs.

Due to Underlying cause Unknown

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE J. B. Broun M. D.

Address Saithersburg Md. Date signed 6-28-48

RECEIVED

JUL 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6322

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda Rural.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:

Six Lane.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Montana County FlatheadCity or town White Fish Rural.
(If outside city or town limits, write RURAL and give nearest town)Street No. 434 Somers Ave.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Clara E. Fontana.

3. (b) Social Security Number

none

4. Sex

Female.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married.6. (b) Name of husband or wife Andrew J. Fontana6. (c) If alive, give age 55 years

7. Birth date of

deceased (mo., day, yr.) October 19 1902

8. AGE:

Years

Months

Days

If less than one day

4582

hrs.

min.

9. Birthplace Omnessee North Dakota.

(Town, county and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name Henry J. Balmer.13. Birthplace St Charles Minnesota.

MOTHER

14. Maiden name Ida Becker.15. Birthplace Becker County Minnesota.

16. Informant

Husband.Address White Fish Montana.17. Burial-Transit Removal June 22, 1948
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Whitefish MontanaLocation Whitefish, Montana

18. Funeral director

Wm. Raymond HumphreyAddress Bethesda, Maryland

19.

6/23 19 48Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 June 19 48 at 9:15 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 June 19 48 to 21 June 19 48
and that I last saw her alive on 21 June 19 48Immediate cause of death Embolic.Cerebral right - - - -Embolic, cerebral right - - -Due to Auricular Fibrillation - -Due to Rheumatic Fever - -cardiac complications - - -

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Not performed.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John B. Ball M.D.

M. D. or other

Address 7436 Georgetown Rd Bethesda Md Date signed 21 June 48

RECEIVED

JUN 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6323

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

9707 Colesville Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 9707 Colesville Road
(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME

MURRELL BAGSHAW FRAZIER

3.(b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married8.(b) Name of husband or wife Louise D. Frazier

6.(c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.)

Dec. 26, 1891

8. AGE:

Years

Months

Days

If less than one day

5658

hrs.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Owner Wholesale Nut Product11. Industry or business Business

MOTHER FATHER

12. Name Marion A. Frazier13. Birthplace Baltimore, Md.14. Maiden name Sarah Anderson15. Birthplace Bel Air, Md.16. Informant Robert A. FrazierAddress 305 Lanark Way, Silver Spring, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 7, 1948
(month) (day) (year)Cemetery or crematory Cedar Hill CemeteryLocation Suitland, Md.18. Funeral director Waxner E. Humphrey, Inc.Address 8434 Ga. Ave., Silver Spring, Md.19. June 6
(Date rec'd by registrar)19. Josephine Schoeffler
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

4 June19 48 at 5:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

22 July18 47 to4 June 19 48

and that I last saw him alive on

4 June19 48

Immediate cause of death

Cardiac decompensation

DURATION

2-3 mo

Due to

Coronary thrombosis3 mo.

Due to

Coronary sclerosis?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William D. Card, M.D.

M.D. or other

Address

Silver Spring, Md.Date signed 5 June 48

AMERICAN MEDICAL ASSOCIATION

RAG CONTENT

RECEIVED
JUN 9 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6324

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 hrs - 10 min
 Hospital, institution, or street address where death occurred: Suburban Hosp.
8600 Old Georgetown Rd - Bethesda Md.
 How long in hospital or institution? 11 hrs - 10 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD 710 Montgomery Lane
 City or town Bethesda Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Mrs Mabel Gatley

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced M
 6. (b) Name of husband Albert S. Gatley
 7. Birth date of deceased (mo., day, yr.) May 25 - 1871
 8. AGE: Years 77 Months _____ Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Tennessee
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John M. Hoge
 13. Birthplace Logan Co., Ohio
 14. Maiden name Margaret Farrington
 15. Birthplace Madison Co., Ohio

16. Informant Mrs Mildred WisdaAddress 4509 Harling Lane - Bethesda17. Burial Burial Date thereof June 11, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Washington, D. C.18. Funeral director Wm. Russell HumphreyAddress Bethesda, Maryland19. 6/10 19 48 Wm E. Johns
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 19 48 at 7 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Tuesday 19 48 to Tuesday 19 48and that I last saw her alive on Tuesday 19 48Immediate cause of death Coronary thrombosis DURATION 12 hoursDue to Arteriosclerotic heart disease 1 yearDue to Exacerbated arteriosclerosis with hyperlipidemia 10 yearsOther conditions Obesity 14 years

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Brues Benjamin M.D. M. D. or otherAddress Bethesda, Md. Date signed 6/18/48

RECEIVED

JUN 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6325

117a

Reg. Dist. No. 217

1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

2 hrs. - 4 a.m.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)Street No. 816 Viers Mill Rd.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Mr. William Gettings

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mrs. Lillian GettingsB. (c) If alive, give age 55 years

7. Birth date of

deceased (mo., day, yr.)

August 23, 1884

8. AGE:

Years

Months

Days

If less than one day

63922

hrs.

min.

9. Birthplace

Montgomery Co. Maryland
(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

FATHER

12. Name

Frank Gettings

13. Birthplace

Rockville, Maryland

MOTHER

14. Maiden name

Frances Bean

15. Birthplace

Maryland

18. Informant

Hospital records

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

6-17-48
(month) (day) (year)

Cemetery or crematory

Rockville Union

Location

Rockville, Md.

18. Funeral director

Wm. Benben Pumphrey

Address

Bethesda, Md.19. 6-15

(Date rec'd by registrar)

19. 48September Fowler

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1948 at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 1948 to June 15 1948and that I last saw him alive on June 15 1948

Immediate cause of death

Cardiac failure

DURATION

5 min.Due to Shock during an operation 5 hours
for perforated gastric ulcer

Due to

Other conditions General peritonitis

(Include pregnancy within 3 months of death)

Major findings of operations Perforation of ulcer on
lesser curvature of stomach Date of op. 6-15-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

J.W. Bird (J.W. Bird)

M. D. or other

Address Sandy Spring, Md. Date signed 6/15/48

MASSACHUSETTS DEPARTMENT OF HEALTH

NEW YORK STATE DEPARTMENT OF HEALTH

NEW YORK STATE DEPARTMENT OF HEALTH

NEW YORK STATE DEPARTMENT OF HEALTH

RECEIVED
JUN 17 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 246

1. PLACE OF DEATH:

County Montgomery
City or town near Potomac, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5-4-48 to 6-24-48
Hospital, institution, or street address where death occurred:
Bre-Crew Rest Home.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Mont.
City or town Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1111 Flower Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

Lillian R. Gilchrist

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Thomas L. Gilchrist
7. Birth date of deceased (mo., day, yr.) July 4, 1872
6. (c) If alive, give age years
8. AGE: Years 75 Months 11 Days 20 If less than one day hrs. min.

9. Birthplace Illinois
(Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER 12. Name Leonard Ward
13. Birthplace Illinois
MOTHER 14. Maiden name Tobithia Graham
15. Birthplace Illinois

16. Informant Mrs. Lillian G. Sime
Address 1111 Flower Ave., Takoma Pk, Md
17. burial ships daughter Date thereof June 26, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Memorial Cemetery
Location Oklahoma City, Oklahoma

18. Funeral director The S. H. Hines Co
Address 2901 14th St NW.

19. 6/25/48 19.48 Wm E. Johns
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1948 at 7:20 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7 19 47 to June 24 19 48
and that I last saw her alive on June 23 19 48
Immediate cause of death Myocardial infarction DURATION
possible the coroner must
investigate - General of L. Ford
Due to due to arterial infarction of L. ventricle Log 7-104
Due to R cerebral aneurysm 243m

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations None Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ch. H. Wolohan M.D. M. D. or other
Address 500 Underwood St NW Date signed June 24, 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6327

83a

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Wheaton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2916 Wheaton Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Wheaton
(If outside city or town limits, write RURAL and give nearest town)Street No. 2916 Wheaton Road
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

HARGETT - MARY P.

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female

white

widowed

6. (b) Name of husband or wife Albert C. Hargett

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 18678. AGE: Years Months Days if less than one day
81 0 5 hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Housewife, retired11. Industry or business Own Home12. Name John McCullough13. Birthplace Ireland14. Maiden name Mary Coleman15. Birthplace Ireland16. Informant Miss Nellie HargettAddress 2916 Wheaton Rd., Wheaton, Md.17. Burial Date thereof June 26, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Mary's CemeteryLocation Rockville, Md.18. Funeral director Waxner & Pumphrey, Inc.Address 8434 Georgia Ave., Silver Spring, Md.19. June 25 19 48 Josephine Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

4:15 AM

20. DATE OF DEATH 6/24/48 19 48 at 4:15 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/12/48 19 48 to 6/24/48 19 48and that I last saw her alive on 6/23/48 19 48

Immediate cause of death

(1) Hemorrhage Central - 1 week

Due to (2) Anterior - 1 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James M. Kington M. D. or otherAddress Kington, Md. Date signed 6/27/48

RECEIVED

JUL 1 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6328

Reg. Dist. No. 714

1. PLACE OF DEATH:

County Mont.City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

39 Primrose St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Mont.City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. 36-Primrose St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARTHA BEACH HARR

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

WILLIAM R HARR

7. Birth date of

deceased (mo., day, yr.)

Nov. 21, 1876

6.(c) If alive, give age

76 years

8. AGE:

Years

Months

Days

If less than one day

71

hrs.

min.

9. Birthplace

IND IND.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

William B. Harney

13. Birthplace

Hartford Conn

14. Maiden name

Martha Beach

15. Birthplace

Conn

16. Informant

Elizabeth Breeze

Address

36 Primrose St

17.

(Burial, cremation, or removal, Which?)

Date thereof

July 1 - 1948

Cemetery or crematory

St. Lincoln's Primrose La

18. Funeral director

Address

2901-14th St. N.W. Wash. D.C.

19.

Date rec'd by registrar

19 48Josephine Schaffer

Register

23. SIGNATURE

Neil P. Campbell

M. D. or other

Address

St. Lawrence St

Date signed

6/28/48

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1948 at 7:35 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 28 1948 to June 28 1948and that I last saw him alive on June 28 1948

Immediate cause of death

Uremia

DURATION

6 days

Due to

Chronic Nephritis5 years

Due to

Other conditions

Cerebral Thrombosis10 monthsC. Rx Hemiplegia
(Include pregnancy within 6 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1948

BUREAU V. S.

Evidence for change of
middle name shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6330

61

Form No. G 11 JUN 25 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery
City or town..... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 5 months, 26 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution?..... 5 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1012 Sigsbee Place, N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war..... WW Sp.Amm. ✓

3. (a) FULL NAME

HARRISON, Robert Anthony William

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married
6.(b) Name of husband or wife..... Francine Harrison
7. Birth date of deceased (mo., day, yr.)..... August 27, 1883
6.(c) If alive, give age..... years
8. AGE: Years..... 64 Months..... 9 Days..... 8 If less than one day..... hrs. min.

9. Birthplace..... Washington, D. C.
(Town, county, and state)
10. Usual occupation..... unemployed
11. Industry or business.....

FATHER 12. Name..... HARRISON, Oliver dec.
13. Birthplace..... Va.
MOTHER 14. Maiden name..... DISHMAN, Annie dec.
15. Birthplace..... Va.

16. Informant..... wife: Mrs. Francine Harrison
Address..... 1012 Sigsbee Pl., N E, Wash., D.C.

17. BURIAL Date thereof..... 6-9-48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory..... Arlington National
Location..... Arlington, Va.

18. Funeral director..... TIMOTHY HANLON RPe
Address..... 641 H St N.E. Washington D.C.
Mary C. Patterson

19. 6-5- 19 48 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5 June 19 48 at 7:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
9 December 19 48 to 5 June 19 48
and that I last saw him in alive on 5 June 19 48

Immediate cause of death.....
Pneumonia - Broncho
uritis, infected, complicated by
Due to..... Arteriosclerosis, General
Due to..... Diabetes Mellitus
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....
Autopsy results..... Same
PHYSICIAN: Please underline the cause to which death should be charged statistically.

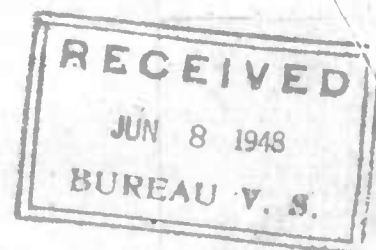
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... W.A. Dinsmore Injured at work?

23. SIGNATURE..... W. A. DINSMORE, Lt Cdr. MC USN
M. D. or other
Address..... USNH Bethesda, Md. Date signed 6-5-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

128

6331

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Olney
 City or town Olney
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 weeks
 Hospital, institution, or street address where death occurred:
Montgo, 62 Sen Hoops
 How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Olney
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. None
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Ethel S. Hawkins3. (b) Social Security Number
Unknown

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Roger Hawkins
 6. (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 4/14/1892
 8. AGE: Years 56 Months 2 Days 14 If less than one day
 .hrs. .min.

9. Birthplace Saunderstown, Md
 (Town, county, and state)

10. Usual occupation Saleswoman11. Industry or business Clothing12. Name Wm. A. Spates13. Birthplace Md14. Maiden name Alena Bready15. Birthplace Md16. Informant Roger HawkinsAddress Olney Md

17. Burial Date thereof July 1, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rockville Union CemeteryLocation Rockville, Maryland18. Funeral director Wm. Rauden PumphreyAddress Rockville, Maryland

19. 6-28 19 48 Bertrude B Dwyer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/28/1948 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/10/48 to 6/28/48
 and that I last saw him alive on 6/28/48 19 48

Immediate cause of death acute Hepatitis DURATION 8 days

Due to acute PancreatitisDue to X Pancreatic autopsy onlyOther conditions Myocardial Acute

(Include pregnancy within 3 months of death)

Major findings of operations cholelithiasisDate of op. 6/14/48Autopsy results none X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

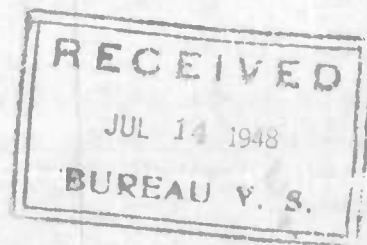
Accident, suicide, or homicide no Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. B. B. M. D. or otherAddress Sandy Spring, Md Date signed 6/28/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6332

95C

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
City or town Rural, Silver Spring, Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

11801 Grand View Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rural, Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 11801 Grand View Ave, Silver Spring
(If rural, give LOCATION)2.(a) If veteran, name war no

3. (a) FULL NAME

Wilson Thomas Henley

3. (b) Social Security Number

578-18-6482

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

Archie Theresa Henley

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

31 July 1868

8. AGE:

Years

Months

Days

If less than one day

79108

hrs. min.

9. Birthplace

Traveler, Montgomery, Md
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

Robert Henley

13. Birthplace

Montgomery Co. Md

14. Maiden name

Sarah Mullan

15. Birthplace

Maryland

16. Informant

Bernard J. Henley

Address

11801 Grand View Ave, Silver Spring

17.

(Burial, cremation, or removal, Which?)

Date thereof

June 8, 1948
(month) (day) (year)

Cemetery or crematory

St. Charles Cemetery

Location

Washington, D.C.

18. Funeral director

Robert H. Mattingly

Address

131-11th St NE Wash DC

19.

Date rec'd by registrar

19.48

Joseph A. Schaeffer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 June 19 48 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10 May 19 48, to 8 June 19 48
and that I last saw him alive on 4 June 19 48

Immediate cause of death

Cardiac Decompensation

DURATION

5-6 mo

Due to

Atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

William D. And Md

M. D. or other

Address

Silver Spring MdDate signed 8 June 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 10 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6333

Reg. Dist. No.

223

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 hr.
Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hosp.
How long in hospital or institution? 8 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 607 Garland Ave T.P.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Un named Baby Hermann

3. (b) Social Security Number

4. Sex Undetermined 5. Color or race wh 6. (a) Single, married, widowed, or divorced S.

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 6-28-48 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
0 0 0 8 hrs. 15 min.

9. Birthplace Takoma Park, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Mr. Arthur F. Hermann

13. Birthplace Providence RI

14. Maiden name Mary Ann Calli

15. Birthplace

16. Informant chart

Address

17. Burial Date thereof June 30, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount Olivet Cemetery

Location Beauregard Road N.E. Washington D.C.

18. Funeral director J. Edwin Walters

Address 254 Carroll St. N.W. Takoma Park D.C.

19. June 29 19 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29 19 48 at 7:28 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-28- 19 48 to 6-29- 19 48

and that I last saw him alive on 6-29- 19 48

Immediate cause of death congenital deformities DURATION

Imperforate anus

Atresia ureteral orifice

Due to Atresia vagina

Due to Atelectasis lungs

Other conditions Prematurity - 35 wks

gestation

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emma Hughes M.D. M. D. or other

Address Takoma Park, Md. Date signed 6-29-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

JUL 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age in especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1952

6334

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH

County MontgomeryCity or town Shroutstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County MontgomeryCity or town German town (Rural)
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Idella Mae Hoes

3. (b) Social Security Number

4. Sex

fe

5. Color or race

col

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Jan 30 1948

8. AGE:

Years

Months

Days

If less than one day

—411

hrs.

min.

9. Birthplace

Monty Co md
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name

Marshall Hoes

13. Birthplace

md

14. Maiden name

Louise Beckwith

15. Birthplace

md

16. Informant

Louise Beckwith

Address

German town md

17.

(Burial, cremation, or removal, which?)

Date thereof

June 13-48
(month) (day) (year)

Cemetery or place of interment

Asbury

Location

German town md

18. Funeral director

Roy W Barber

Address

Beltsville md

19.

Date rec'd by registry

June 18 1948 Abunda L Goode
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1948 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1948 to June 1948and that I last saw him alive on June 11 1948

Immediate cause of death

DURATION

Asphyxia
thrombotic

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 6/11/48Where did injury occur? German town md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) home

Means of injury

Injured at work?

June J. Brumhart md

23. SIGNATURE

Idella Mae Hoes

M. D. or other

Address German town md Date signed 6/11/48

RECEIVED

JUN 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6335 214

1. PLACE OF DEATH:

County... MontgomeryCity or town... Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

204 Eastwood Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... MontgomeryCity or town... Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No... 204 Eastwood Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

LUCIENNE S. HOLMBERG

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white married6. (b) Name of husband or wife... John B. Holmberg

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years

Feb. 1, 18968. AGE: Years Months Days If less than one day
52 4 12 hrs. min.9. Birthplace... Paris, France
(Town, county, and state)10. Usual occupation... Housewife11. Industry or business... Own Home12. Name... Louis Auger13. Birthplace... Paris, France14. Maiden name... Delphine Unknown15. Birthplace... Paris, France16. Informant... John B. Holmberg, Maj. USA retiredAddress... 204 Eastwood Ave., Silver Spring, Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof... June 16, 1948
(month) (day) (year)Cemetery or crematory... Arlington National CemeteryLocation... Fort Myer, Va.18. Funeral director... Werner E. Humphrey, Inc.Address... 8434 Ga. Ave., Silver Spring, Md.19. Date rec'd by registrar... June 14, 1948 Josephine Schaeffer

MEDICAL CERTIFICATION

20. DATE OF DEATH... June 13, 1948 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

May 25, 1947 to June 13, 1948and that I last saw him alive on June 13, 1948Immediate cause of death... cardiac failure

DURATION

3 daysDue to... thrombus 3 mosDue to... arterial obstr. by carcinoma 10 yrsOther conditions... uterus retroverted

(Include pregnancy within 3 months of death)

Major findings of operation... Recent carcinoma inuterus, urinary bladder Date of op... May 25, 1947

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Dr. J. Lewis M.D.Address... 915 19th St NW Washington D.C. Date signed... 6/13/48

RECEIVED

JUN 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6336

Reg. Dist. No. 211

1. PLACE OF DEATH:

County MONTGOMERYCity or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 YRS.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County MONTGOMERYCity or town HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

EDWARD MALANGLTON HORINE

3. (b) Social Security Number

4. Sex MALE5. Color or race WHITE6. (a) Single, married, widowed, or divorced MARRIED8. (b) Name of husband or wife MINERVA C. HORINE7. Birth date of deceased (mo., day, yr.) 8-31-1964

8. (c) If alive, give age _____ years

8. AGE: Years 83 Months 10 Days 7 If less than one day _____ hrs. _____ min.9. Birthplace BURKETSVILLE MD.
(Town, county, and state)10. Usual occupation FARMING

11. Industry or business _____

12. Name JOHN A. HORINE13. Birthplace FREDERICK CO. MD.14. Maiden name ELIZABETH GROVE15. Birthplace FREDERICK CO.16. Informant MINERVA C. HORINEAddress HYATTSVILLE MD.17. BURIAL Date thereof 6-14-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory HYATTSVILLELocation HYATTSVILLE MD.18. Funeral director W. L. BURDETTEAddress HYATTSVILLE MD.19. June 12 1948 W. L. Burdette
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1948 at 2:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1947 to June 11 1948 and that I last saw him alive on June 7 1948Immediate cause of death Coronary occlusion DURATION 2 yrs.Due to Arterio sclerosis 10 yrs.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Ernest P. Roof, M.D. M. D. or otherAddress New Market, Md. Date signed June 11/48

HEALTH TO THE PEOPLE OF THE UNITED STATES

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

AGE OF DECEASED

SEX OF DECEASED

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RECEIVED
JUN 15 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6337

Reg. Dist. No. 416

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:

9016 Old Georgetown Road,How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 9016 Old Georgetown Road,
(If rural, give LOCATION)2.(a) If veteran, name war No

3. (a) FULL NAME

John Lewis Imirie

3. (b) Social Security Number

579-01-9974

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Christena E. Imirie6. (c) If alive, give age 51 years7. Birth date of deceased (mo., day, yr.) December 23, 18968. AGE: Years Months Days If less than one day
51 51 5 12 hrs. min.9. Birthplace Washington, D. C.
(Town, county, and state)10. Usual occupation Printing and Office Supplies11. Industry or business None12. Name Peter Imirie13. Birthplace Washington, D. C.14. Maiden name Margaret Batchen15. Birthplace Washington, D. C.16. Informant Mrs. Christena E. ImirieAddress Bethesda, Maryland17. Burial Date thereof June 8, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Glenwood CemeteryLocation Washington, D. C.18. Funeral director Wm. Paulsen RumphreyAddress Bethesda, Maryland19. 6/6/ 48 Wm E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1948 19..... at 1:50A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15, 1948, to June 5, 1948
and that I last saw him alive on June 4, 1948Immediate cause of death Carcinoma of Colon DURATION 2 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma colon at hepatic flexure Date of op. 7/3/48Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Wm. E. Jones M. D. or otherAddress 3921 Douglass Rd Date signed 6-5-48

RECEIVED

JUN 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164 C

6338

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:

County Montgomery
 City or town Damascus Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Long years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Damascus Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) m
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles William Johnson

3. (b) Social Security Number

213-12-1719

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Nettie Johnson
 6.(c) If alive, give age 60 years
 7. Birth date of deceased (mo., day, yr.) August 14 - 1884
 8. AGE: Years 63 Months 9 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Culpeper Culpeper Va
 (Town, county, and state)

10. Usual occupation School

11. Industry or business Elgerson Johnson

12. Name Virginia

13. Birthplace Mary E Grimsley

14. Maiden name Virginia

15. Birthplace Mrs Nettie Johnson

16. Informant Damascus Md

17. Burial Date thereof June 12 - 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Providence

Location Howard Co Md

18. Funeral director Boj W Barber

Address Lafayetteville Md

19. June 12 19 48 Lella W. Bartlett
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 19 48 at 5:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med Exam case to 19 and that I last saw live on 19

Immediate cause of death Gun shot wound
Three skulls
 Due to (suicide)

DURATION

dis
nature

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 6-10-48

Where did injury occur? Damascus Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Shot gun Injured at work? no

23. SIGNATURE Frank J. Boerhaart Md

Dep Med. Exam M. D. or other

Address Yantherburg Md Date signed 9-10-48

RECEIVED

JUN 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6339

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Hollywood Park, Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hollywood Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Hollywood Park, Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. Hollywood Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

PAULINE M. KELLY

3. (b) Social Security Number

578-32-5231

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female

white

married

6. (b) Name of husband or wife Harold L. Kelly7. Birth date of deceased (mo., day, yr.) Oct. 25, 18938. AGE: Years Months Days If less than one day
54 7 10 hrs. min.9. Birthplace McKinney, Ky.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Greene Moore13. Birthplace Kentucky14. Maiden name Margaret Victoria Bibb15. Birthplace Bristol, Tenn.16. Informant Harold L. KellyAddress Hollywood Park, Silver Spring, Md.17. Burial Date thereof June 9, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory George Washington Memorial CemeteryLocation Riggs Rd., Pr. Geo. Co., Md.18. Funeral director Warner E. Humphrey, Inc.Address 8434 Ga. Ave., Silver Spring, Md.19. June 7 19 48 Joseph W. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 19 48 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 19 to 19and that I last saw him Sept. 19 alive on Sept. 19

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

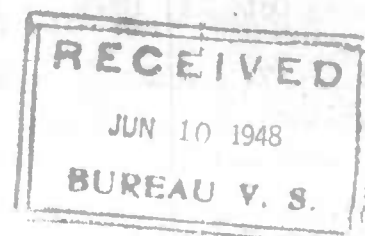
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Broschart M.D. M. D. or otherAddress Fairbury Md. Date signed 6/5/48



RECEIVED

JUL 6 1948

BUREAU V. S.

Birth and Death . 6341
159

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 217

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Montgomery
City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street address, hospital, or institution:
The Montgomery County General Hospital Inc.
Length of mother's stay in County _____
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. R-2 Fairland
(If RURAL give LOCATION)

3. Name of child Kirk
5. Sex Female | 6. Twin or triplet —

4. Date of birth June 17, 1948 Hour 9:00 P.M.
7. No. of weeks pregnancy 21 weeks

FATHER OF CHILD

8. Full name Carson Nathaniel Kirk
9. Color White 10. Age at time of this birth 27 yrs.
11. Usual occupation Jockey

MOTHER OF CHILD

12. Full maiden name Esther Regina Hooe
13. Color White 14. Age at time of this birth 25 yrs.
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 2
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No
18. Pregnancy, complications of _____

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
(a) Fetal causes cannot determine
(b) Maternal causes —

19. Labor: (a) Complications of _____ (b) Induced? _____

20. (a) Was there an operation for delivery? No
(Yes or No)
(b) State all operations, if any _____

22. I certify to the birth of this child who was born dead* on the date and hour above stated:

Signature [Signature]
(Specify if M.D., midwife, or other)

(c) Did child die before operation? +
During operation? —

Address Sandy Spring, Md.

23. (a) Burial (b) Date thereof June 18, 1948
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Colonial Church

25. (a) 6-18-48 (b) Esther B. Zimler
(Date rec'd by registrar) (Registrar)

24. (a) Funeral director Wm. C. Humphrey Inc.
(b) Address Silver Spring, Md.

26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per _____

* See Instruction C on stub.

Child lived one hour

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JUN 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1600

6342

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Va. County...
 City or town... Arlington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Arlington
 (If rural, give LOCATION)
 2.(a) If veteran, name war... ☒

3.(a) FULL NAME

KIRKLAND, William Charles, Jr.

3.(b) Social Security Number

4. Sex... male 5. Color or race... W-US 6.(a) Single, married, widowed, or divorced... single
 6.(b) Name of husband or wife...
 7. Birth date of deceased (mo., day, yr.)... 4 June 1948 6.(c) If alive, give age... years
 8. AGE: Years... Months... Days... If less than one day... hrs. ... min.
3

9. Birthplace... Bethesda, Maryland (rural)
(Town, county, and state)

10. Usual occupation...

11. Industry or business...

FATHER 12. Name... KIRKLAND, William C.13. Birthplace... Ga.MOTHER 14. Maiden name... QUEEN, Bess15. Birthplace... N.C.16. Informant... father: TSgt. William C. KirklandAddress... 1011 N. Edgewood St., Arlington, Va.17. burial Date thereof... 6-8-48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory... Arlington NationalLocation... Arlington, Va.18. Funeral director... W. W. CHAMBERSAddress... Georgetown, D.C.19. 6-7- 48 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 7 June 19 48, at 5:59A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 June 19 48, to 7 June 19 48and that I last saw him alive on 7 June 19 48Immediate cause of death... intra cranial injury DURATION

Due to...

Due to...

Other conditions... Pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations...

Autopsy results... Confirmed the above Date of op...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

23. SIGNATURE... PAUL PETERSON, Capt. MC USN M. D. or otherAddress... USNH Bethesda, Md. Date signed 6-7-48

RECEIVED

JUN 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age shown on:

SUM No. G 116 AUG 6 - 1948

MARYLAND STATE DEPARTMENT OF HEALTH ✓

2411 N. Charles St., Baltimore

6343

CERTIFICATE OF DEATH 462

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 mo
Hospital, institution, or street address where death occurred:
4615 Chestnut Avenue,
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4615 Chestnut Avenue
(If rural, give LOCATION)
2. (a) If veteran, name war No

3. (a) FULL NAME

Mrs. Emma R. Kline

3. (b) Social Security Number
None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife W. E. Kline

6. (c) If alive, give age 56 years

7. Birth date of
deceased (mo., day, yr.)

November 16, 1895

8. AGE:

Years

Months

Days

It less than one day

55 53

6

12

hrs. min.

9. Birthplace Harrisburg, Pennsylvania
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

None

12. Name James T. Howe

13. Birthplace Unknown

14. Maiden name Roseanna Cleder

15. Birthplace Unknown

16. Informant Mr. W. E. Kline

Address Bethesda, Maryland

17. Burial June 10, 1948
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location Washington, D. C.

18. Funeral director Wm. Hansen Pumpfrey

Address Bethesda, Maryland

19. 6/10 19 48
(Date rec'd by registrar)

Wm E Jones
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 19 48 at 5:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-6-47 to 6-8-48

and that I last saw her alive on June 7 19 48

Immediate cause of death Cerebral

decompensation

DURATION

Due to Carcinoma of Esophagus

Carcinoma of Esophagus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Esophagus

2 Metastases Date of op. 9-23-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

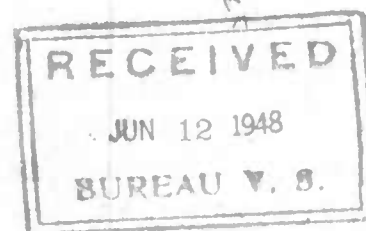
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm E Jones M. D. or other

546 N. Charles St. / Bethesda, Md Date signed 6-8-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6344

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 days
 Hospital, institution, or street address where death occurred:
Suburban Hospital
 How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9011 Linton St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

MR. A. WILLIAM KREAMER

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mrs. Jane Kreamer
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) November 20, 1888
 8. AGE: Years 59 Months 6 Days 29 If less than one day..... hrs. min.

9. Birthplace Williamsburg, Pennsylvania
 (Town, county, and state)
 10. Usual occupation Civil Engineer
 11. Industry or business
 12. Name William Kreamer
 13. Birthplace Williamsburg, Pennsylvania
 14. Maiden name Minnie Dittman
 15. Birthplace Germany

16. Informant Wife
 Address
 17. Removal Date thereof June 20, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory
 Location Phila. Pa.
 18. Funeral director W. H. Chambers & Co.
 Address Wash. D.C.
 19. 6/20 1948 Wm E Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1948 19..... 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1 June 1948 to 19 June 1948
 and that I last saw him alive on 19 June 1948

Immediate cause of death Coronary Occlusion with myocardial infarction
 DURATION 19 days

Due to.....
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations none
 Date of op.
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE S. R. Bowersfield M.D.
 M.D. or other
 Address 7345 Wisconsin Ave Date signed 20 June 48

RECEIVED

JUN 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6345

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MONTGOMERY
 City or town BETHESDA, MARYLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? SEVEN YEARS
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MARYLAND County MONTGOMERY
 City or town BETHESDA
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4501 CHASE AVE.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

HENRY QUIMBY LAYMAN

3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED
 6.(b) Name of husband or wife ESTHERINE HOFFMAN
 6.(c) If alive, give age 57 years
 7. Birth date of deceased (mo., day, yr.) Sept. 28, 1883
 8. AGE: Years 64 Months 8 Days 9 If less than one day
 hrs. min.

9. Birthplace CHESTERTOWN, MARYLAND
 (Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

12. Name HENRY CLAY LAYMAN
 13. Birthplace DELAWARE
 14. Maiden name SUSANNA BROCK
 15. Birthplace KENT COUNTY, MARYLAND

16. Informant WIFE

Address 4501 CHASE AVE. BETHESDA, MD.

17. Burial Date thereof June 9, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Liberty City Burial

Location Wilmington, Del.

18. Funeral director Neal Funeral Home

Address 4812 Mc Quenry West DC

19. 6-7 19 48 Wm E Jones
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 6 19 48 at 8:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 6 19 48 to JUNE 6 19 48 and that I last saw him alive on JUNE 6 19 48

Immediate cause of death MASSIVE CEREBRAL HEMORRHAGE DURATION 28 May 48

Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE 1940-

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Emilie B. Black, M.D. M. D. or other

Address 7936 Quantown Rd. Date signed 6-6-48

1150th St. Md.

RECEIVED
JUN 11 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6346

Reg. Dist. No. 216

1. PLACE OF DEATH: Montgomery
 County.....
Bethesda (rural)
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 27 days
 Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, Bethesda, Md.
 How long in hospital or institution? 2 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....Washington..... County.....
 City or town.....District of Columbia
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1402 15th St., N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....WWII

3.(a) FULL NAME

LEWIS, John Monroe

3.(b) Social Security Number

4. Sex Male 5. Color or race Col 6.(a) Single, married, widowed, or divorced separated
 6.(b) Name of husband or wife Mrs. Bessie Lewis
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) October 27, 1900
 8. AGE: Years Months Days If less than one day
47 7 13hrs.min.
 9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation Janitor
 11. Industry or business

12. Name Unknown
 13. Birthplace unknown
 14. Maiden name unknown
 15. Birthplace unknown

16. Informant wife: Mrs. Bessie Lewis
 Address 903 5th St., Richmond, Va.
 17. burial Date thereof 6-15-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Arlington National Cemetery
 Location Arlington, Va.

18. Funeral director W. Ernest Jarvis
 Address 1432 U St., N. W., Wash. D.C.
 19. 6-11 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 June 19 48 at 11:58A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
13 March 19 48 to 10 June 19 48
 and that I last saw him alive on 10 June 19 48

Immediate cause of death Meningitis DURATION 3 months

Due to Intracranial Injury 3 months

Due to

Other conditions Hydrocephalus and broncho pneumonia
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results..... confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE W. J. James M. D. or other 6-11-48
W. J. JAMES, Cdr. MC USN
USNH Bethesda, Md.
 Address..... Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 16 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

6347

216

1. PLACE OF DEATH:

County Montgomery

City or town Potomac

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 6 days

Hospital, institution, or street address where death occurred:

Pine View Rest Home

How long in hospital or institution? 1 yr. 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Nashington County D.C.

City or town Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1418 Somerset Pl. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

John Heaton Linvill

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife Bertha R.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 10, 1876

8. AGE: Years Months Days If less than one day

71

71

9

19

.....hrs.

.....min.

9. Birthplace Urban, Ohio

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name John Q. Adams Linvill

13. Birthplace Urban, Ohio

MOTHER 14. Maiden name Jennette Wierman

15. Birthplace Urban, Ohio

16. Informant Lt. Col. Robert R. Linvill

Address 1418 Somerset Pl. N.W. Washington D.C.

17. Burial - Transit Date thereof June 29, 1948

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Springfield Cem.

Location Springfield, Ohio

18. Funeral director Wm. Randolph Humphrey

Address Bethesda, Maryland

19. June 29, 1948

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1948 at 4:35 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 22 1947, to June 29 1948

and that I last saw him alive on June 29 1948

Immediate cause of death

Cerebral Thrombosis

DURATION

2 days

Due to Chr. instit nephritis 10 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations No operation

.....Date of op.

Autopsy results No Autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. R. West M. D. or other

Address 3140 Klinge Rd. N.W. Date signed 6-29-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

JUL 6 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since 6-16-48 - 3:00 P.M.
Hospital, institution, or street address where death occurred: Suburban Hosp.
8600 Old Georgetown Rd - Bethesda Md.
How long in hospital or institution? since 6-16-48 - 3:00 P.M.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6605-8th St N.W.
(If rural, give LOCATION)
2(a) If veteran, name war _____ ✓

3. (a) FULL NAME
Mr Joseph Littman

3. (b) Social Security Number

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Fannie Littman

7. Birth date of deceased (mo., day, yr.) Jan., 29, 1881 6. (c) If alive, give age 59 years

8. AGE: Years 67 Months 5 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Hungary
(Town, county, and state)

10. Usual occupation merchant-ladies dresses

11. Industry or business

12. Name Meyer Littman

13. Birthplace Hungary

14. Maiden name Hannah Gross

15. Birthplace Poland Russia

18. Informant Wife - Fannie Littman

Address

17. Removal Date thereof _____ (month) (day) (year)
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director B. Ranzanich & Son

Address 3501-14th St. N.W. Wash.

19. 6/17 19 48 Wm E Jobie
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17 19 48 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 47 to June 17 19 48
and that I last saw him alive on June 17 19 48

Immediate cause of death Cerebral Hemorrhage DURATION 36 hrs.

Due to Hypertension Chronic 10 yrs.

Due to Hypertensive Heart Disease 10 yrs.

Other conditions Diabetes Mellitus 10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. D. Damiano MD

Address 2700 Que St NW Date signed 6-17-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 21 1948

BUREAU V. S.

512 Maple Ridge Rd.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for Items 12 & 13:
 FILM NO. G 116 JUN 25 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6349

Reg. Dist. No. 814

1. PLACE OF DEATH:

County Montgomery
 City or town Capitol View
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

46 Walnut St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Capitol View
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 46 Walnut St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MALCOLM Amanda Storer Malcolm

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife James E. Malcolm

7. Birth date of deceased (mo., day, yr.) July 6, 1887 6.(c) If alive, give age _____ years

8. AGE: Years 60 Months 11 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Ohio
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Stacey S. Storer, Samuel H.13. Birthplace Ohio, Highland Co.14. Maiden name Lucy Ball15. Birthplace Ohio16. Informant Mr. James E. MalcolmAddress 46 Walnut St., Capitol View

17. Burial Date thereof June 12, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Spesutia ChurchLocation Perryman, Hartford Co., Md.18. Funeral director Warner E. Pumphrey, Inc.Address 8434 Ga. Ave., Silver Spring, Md.

19. June 10 19 48 Joseph M. Schaeffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9/48 19 11:40 P.M. at _____ M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/29/48 19 _____, to 6/5/48 19 _____, and that I last saw him alive on 6/5/48 19 _____.

Immediate cause of death

Carcinoma: Peticulum Cell
 Due to generalized
Primary site unknown
 Due to Involved sternal abdomen
skin etc.

DURATION

1 1/2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Samuel Allen M.D. or other MD
 Address Kewington, Md. Date signed 6/10/48

RECEIVED

JUN 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6391

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
 City or town Olney
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 mo 6 days
 Hospital, institution, or street address where death occurred:
Montgomery Co. Gen. Hospital
 How long in hospital or institution? 3 mo 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Elkton Springs
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1549 Falkland Lane
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War I

3. (a) FULL NAME

TYSON MARSHALL

3. (b) Social Security Number

4. Sex Male 5. Color or race Wh 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Margaret Marshall

7. Birth date of deceased (mo., day, yr.) July 22, 1893 6.(c) If alive, give age 57 years

8. AGE: Years 54 Months 11 Days 1 It less than one day hrs. min.

9. Birthplace Wilmington, Delaware
 (Town, county, and state)

10. Usual occupation Police Clerk

11. Industry or business

12. Name Robert E. Marshall

13. Birthplace England

14. Maiden name Miss Martha Tyson

15. Birthplace Maryland

16. Informant Mrs. Margaret Marshall

Address 1549 N. Falkland Lane Elkton

17. Burial Date thereof June 25, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Warrinton Cemetery

Location Fauquier Co. Virginia

18. Funeral director Warren E. Humphrey, Inc.

Address 8434 Aringia Ave. Silver Spring, Md.

19. June 24 19 48 Josephine Schaeffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 19 48 at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17 19 48 to June 23 19 48 and that I last saw him alive on June 23 19 48

Immediate cause of death Cerebral occlusion

Due to Pericarditis Mucosa

Due to Sulfonamide Allergy

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H. Zigon per R.P.W.
 M. D. or other

Address Montgomery Co. Health Dep. Date signed 6-23-48

RECEIVED

RECEIVED

RECEIVED

JUL 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 days
 Hospital, institution, or street address where death occurred:
Washington San. & Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Montgomery
 City or town Takoma Park Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 120 Park Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mason, Mrs. May

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Noel W. Mason
 7. Birth date of deceased (mo., day, yr.) 5-16-68 8.(c) If alive, give age 79 years
 8. AGE: Years 80 Months 1 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Mt. Vernon, Ill.
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name John Slade
 13. Birthplace Alabama
 MOTHER 14. Maiden name Leona Patton
 15. Birthplace ILL.

16. Informant Hospital Records

Address Burial
 17. June 29-1948
 (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or cremation St. Anthonys
 Location N. Geo. & Md.

18. Funeral director The B.H. Hines Co.

Address 2901-14 St. N.W. Washington D.C.

19. June 27 1948
 Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1948 at 9:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 30 1947 to June 27 1948
 and that I last saw him alive on June 25 1948

Immediate cause of death Gen. metastasis of DURATION

Adeno carcinoma of uterus
 Due to 6 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

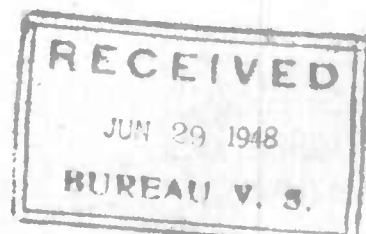
Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

Signature Howard I. Moore

Address 2800 Carroll Ave. Takoma Park Md.

Date signed 6/27/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6351

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Bethesda, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5510 Greentree Road,
 (If rural, give LOCATION)
 2(a) If veteran, name war World War I

3. (a) FULL NAME

Jack Arthur Mathew

3. (b) Social Security Number

554-09-5064

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Dorothy G. Mathew
 6. (c) If alive, give age 41 years
 7. Birth date of deceased (mo., day, yr.) January 29, 1889
 8. AGE: Years 59 Months 59 Days 4 It less than one day 18 hrs. min.

9. Birthplace Rosedale, Kansas
 (Town, county, and state)
 10. Usual occupation Printer
 11. Industry or business None

FATHER 12. Name William Mathew
 13. Birthplace Ohio

MOTHER 14. Maiden name Florence M. Lawson
 15. Birthplace West Virginia

16. Informant Mrs. Dorothy G. Mathew
 Address Bethesda, Maryland

17. Burial Burial Date thereof June 22, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National Cemetery
 Location Arlington, Virginia

18. Funeral director Wm. Herbert Humphrey
 Address Bethesda, Maryland

19. 6/18/48 Wm E Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 19 48 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 2 19 48 to June 17 19 48
 and that I last saw him alive on May 19 48

Immediate cause of death Coronary Thrombosis

DURATION

4 1/2

Due to Coronary arteriosclerosis months

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paula E. Mahler, M.D.

Address 8712 Old Georgetown Rd M. D. or other 6-18-48
 Date signed

RECEIVED

JUN 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 114

1. PLACE OF DEATH:

County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 yrs
 Hospital, institution, or street address where death occurred:
1608 East West Highway
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montg
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1608 East West Highway
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Margaret Sela Herfurth Mays

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct 6 1905

8. AGE: Years 42 Months 7 Days 28 hrs. _____ min.

9. Birthplace Washington DC
 (Town, county, and state)

10. Usual occupation house

11. Industry or business 7

12. Name Mrs F. Herfurth

13. Birthplace Wash DC

14. Maiden name Margaret A. Thompson

15. Birthplace Baltimore Md.

16. Informant Mrs Margaret A. Mays Fair

Address 1608 E. W. Hwy. Silver Spring Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 7 1948
 (month) (day) (year)

Cemetery or crematory Christ Church Cemetery

Location Accokeek, Md.

18. Funeral director The S. H. Hines Co.

Address 2901 - 14th St. N.W.

19. June 4 1948 (Date rec'd by registrar) Joseph A. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1948 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep Med Exam case 19 to 19

and that I last saw h. _____ alive on _____ 19

Immediate cause of death _____

DURATION

abrupt
suddenly

Major findings of operations _____

RECEIVED

JUN 9 1943

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

6353

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
City or town Farmers Port md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 daysHospital, institution, or street address where death occurred:
Washington San. & HospHow long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town College Park md
(If outside city or town limits, write RURAL and give nearest town)Street No. 4707 Calvert Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

McCall, Mrs. Harriett Marie

3. (b) Social Security Number

4. Sex Fe 5. Color or race White 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Arthur G. McCall7. Birth date of deceased (mo., day, yr.) Sept. 13, 1871 6.(c) If alive, give age 22 years8. AGE: Years 76 Months 5 Days 1 If less than one day 7 hrs. 50 min.9. Birthplace Ironton Ohio
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name William Flower13. Birthplace Ohio14. Maiden name L. Herdman

15. Birthplace

16. Informant Hospital Records

Address

17. Removal Date thereof June 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory F. Gasch's Funeral HomeLocation Hyattsville18. Funeral director F. Gasch's SonsAddress Hyattsville, Md19. June 2, 1948 Registrar J. William Webb

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1948 8:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19, 1948 to June 2, 1948and that I last saw him alive on June 1, 1948Immediate cause of death Myocardial InfarctionDURATION 2 weeksDue to Central arteriosclerosisDue to Serious

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

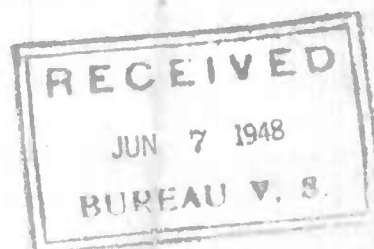
Means of injury Injured at work?

23. SIGNATURE Wm. B. R. Webb M.D. or otherAddress 6920 Farm B. Rd. Date signed 6/2/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Reg. Diat. No. 216

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 25 Lawrence Avenue
(If rural, give LOCATION)
No

2.(a) If veteran, name war _____

3. (b) Social Security Number
None

MEDICAL CERTIFICATION
June 29, 1948 19 330 AM

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from
May 21 19 45 to June 29 19 48
and that I last saw h. on June 28 19 48
alive on.....

Immediate cause of death.....

DURATION.....

Due to.....
Due to.....
Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. **VIOLENCE:** If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bradley D. Hopkins MD M.D. or other _____

Address 313 W Bradley Lake Date signed 6/29/88

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6355

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 212 O Street, S. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WWI

3.(a) FULL NAME

McGRATH, James Francis

3.(b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Helen McGrath
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 21 September 1888
 8. AGE: Years 59 Months 8 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Mass.
 (Town, county, and state)
 10. Usual occupation Civil Service
 11. Industry or business _____
 12. Name McGrath, Michael dec.
 13. Birthplace Ireland
 14. Maiden name Sheridan, Mary dec.
 15. Birthplace Ireland

16. Informant wife: Mrs. Helen McGrath
 Address 212 O St., S.W., Wash., D.C.
 17. burial Date thereof 6-14-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National Cemetery
 Location Arlington, Va.
 18. Funeral director W. W. CHAMBERS
 Address 517 11th St., S.E. Wash. D.C.
Mary C. Patterson
Registrar
 19. 6-14-48
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 June 1948 at 2:20 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 June 1948 to 10 June 1948
 and that I last saw him alive on 10 June 1948
 Immediate cause of death Bronchopneumonia DURATION 2 days
 Due to uremia 4 days
 Due to nephritis, chronic unknown
 Other conditions Hypertension, arterial unknown
 (Include pregnancy within 8 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results confirmed above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE R. L. FLECK, Lt. MC USN M. D. or other _____
 Address USNH Bethesda, Md. Date signed 6-14-48

RECEIVED

JUN 16 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

6356

93d

1. PLACE OF DEATH:

County Montgomery
City or town Olney
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 3/4 hours
Hospital, institution, or street address where death occurred:
Montgomery County General HospitalHow long in hospital or institution? 1 3/4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County HowardCity or town Glenwood
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

ISABELLA STINSON MILES

3. (b) Social Security Number

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced WIDOWED8. (b) Name of husband or wife OLIVER SCOTT MILES7. Birth date of deceased (mo., day, yr.) APRIL 3, 1885 8. (c) If alive, give age _____ years8. AGE: Years 63 Months 1 Days 28 If less than one day _____ hrs. _____ min.9. Birthplace GLENWOOD, MARYLAND
(Town, county, and state)10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name HENRY DORSEY13. Birthplace GLENWOOD, MARYLAND14. Maiden name LUCIE AMERICA15. Birthplace GLENWOOD, MARYLAND16. Informant EVELYN DUTTONAddress GLENWOOD, MARYLAND17. Burial Burial Date thereof May 4, 1948
(Burial, cremation, or removal, Which) (month) (day) (year)Cemetery or crematory Bushy ParkLocation Cockeysville, Howard Co18. Funeral director W. H. BarberAddress Cockeysville, Md19. 6-4 19 48 Bertrude B Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 1, 1948 at 4:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 25, 1948 to JUNE 1, 1948 and that I last saw her alive on JUNE 1, 1948

Immediate cause of death _____ DURATION

ACUTE CARDIAC FAILURE 1 HR.Due to CARDIAC INSUFFICIENCY 6 WKSDue to ARTERIO SCLEROTIC HT. DISEASE 1 YR.Other conditions AURICULAR FIBRILLATION 6 WKS
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles S. Whitaker, M.D.
M.D. or other _____Address Clarksuite, Md. Date signed 6-1-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 17 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

6357

183

714

1. PLACE OF DEATH:

County... Montgomery
City or town... Burnt Mills Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ?
Hospital, institution, or street address where death occurred:
North West Branch
How long in hospital or institution? ?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... MD County... Washington
City or town... Washington DC
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1507 Vermont Ave
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME

Raymond Miller

3. (b) Social Security Number

4. Sex Male 5. Color or race Col 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) November 6, 1933 6.(c) If alive, give age 15 years

8. AGE: Years 14 Months 7 Days 6 If less than one day hrs. min.

9. Birthplace Ridgeway S.C.
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

12. Name Raymond Miller
13. Birthplace South Carolina
14. Maiden name Essie Skipper
15. Birthplace South Carolina

16. Informant Raymond Miller

Address 1507 Vermont Ave. N.W.

17. Date thereof June 15, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Prosperian Cemetery

Location Ridgeway S.C.

18. Funeral director Robert McQuinn

Address 1820 - 9th St. N.W. Wash. D.C.

19. June 14 19 48 Joseph M. Schaeffer
(Date rec'd by registrar) Register

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1948 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Depressed state and that I last saw him alive on June 13, 1948

Immediate cause of death Asphyxia by drowning

Due to (accidental)

Due to and

Other conditions fast

(Include pregnancy within 3 months of death)

Major findings of operations and

Autopsy results and

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6/13/48

Where did injury occur? Burnt Mills Monty Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) North West Branch

Means of injury drowning Injured at work? no

23. SIGNATURE Frank J. Bronckart M.D.

Address Washington Md Date signed 6-13-48

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HO 2500

RECEIVED

JUN 17 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 months
 Hospital, institution, or street address where death occurred:
Ten Thousand Georgia Avenue,
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia D. C.
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3710 Jenifer St., N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3. (a) FULL NAME

Mrs. Mary D. Moore

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Frank Moore
 7. Birth date of deceased (mo., day, yr.) (Unknown) 1889 6.(c) If alive, give age dec. years
 8. AGE: Years 89 Months 89 Days If less than one day hrs. min.

9. Birthplace Washington, D. C.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business None
 12. Name Thomas Larned
 13. Birthplace Unknown
 14. Maiden name Carolyn Hill
 15. Birthplace Unknown

16. Informant Mrs. Jean H. Hawley
 Address 3710 Jenifer St., N.W., Wash. D.C.
 17. Burial Date thereof June 29, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Paul's Cemetery
 Location Alexandria, Virginia
 18. Funeral director Wm. Reuben Thompson
 Address Bethesda, Maryland

19. June 28 19 Joseph M. Schoeffe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 48 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 21 19 48 to June 26 19 48
 and that I last saw him alive on June 26 19 48

Immediate cause of death Acute Myocarditis
 DURATION

Due to SenilityDue to Malnutrition

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph M. Schoeffe M.D.Address 1603 994 St. N.W. Date signed 6-27-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

1857

89

1948

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JUL 1 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH

County Montgomery Co.
City or town Bethesda Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Prs Geo
City or town 4704 - 40th Ave
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hyattsville Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George H. Morley

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
6.(b) Name of husband or wife Mary E. Morley
7. Birth date of deceased (mo., day, yr.) 1861 6.(c) If alive, give age years
8. AGE: Years 87 Months Days If less than one day hrs. min.

9. Birthplace England
(City, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name John Morley

13. Birthplace England

14. Maiden name unknown

15. Birthplace England

16. Informant Arletta M. Moore

Address 5500 McKinley St Bethesda Md

17. Burial Date thereof June 14, 1948
(Burial, cremation, or funeral. When?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Hyattsville Md

18. Funeral director F. Pascha Sons

Address Hyattsville Md.

19. 6/14 19 48 7pm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 June 19 48 at 1:30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 26 to 11 June 19 48
and that I last saw him alive on 11 June 19 48

Immediate cause of death acute dilatative heart DURATION 2 days

Due to Generalized arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas E. Mattenly M.D. M. D. or other

Address 2200 R.I. Ave N.E. Date signed 11 June 48
Washington DC

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1981
—
1967
148

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JUN 16 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6360

83a

Reg. Dist. No. 226

1. PLACE OF DEATH:

County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Mont'gy.
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6024 Western Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

LULA L. MORRIS

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, Widowed or divorced

6.(b) Name of husband or wife James Morris 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 27, 1865

8. AGE: Years 82 Months _____ Days _____ It less than one day _____ hrs. _____ min.

9. Birthplace Montrose, Pa
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Isaac Runyon
13. Birthplace Pa.

MOTHER 14. Maiden name Josephine L. Watkins
15. Birthplace Pa.

16. Informant Mrs. Viola M. Creason
Address 6024 Western Ave., Md.

17. Burial Date thereof June 28, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill

Location

18. Funeral director The S.H. Hines Co
Address 2901 14th St NW

19. 6/26 19 48 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 48 at 12:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 19 48 to June 26 19 48 and that I last saw him alive on June 25 19 48

Immediate cause of death Sudden Congestive Heart Failure DURATION 5 days

Due to Cerebral Hemorrhage DURATION 8 days

Other conditions none

(Include pregnancy within 3 months of death)
Major findings of operations no operation Date of op. _____

Autopsy results no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William J. Gifford M.D. or other
Address 1746 - K Street NW Date signed 6/26/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

6361

CERTIFICATE OF DEATH

Reg. Dist. No. 212.

1. PLACE OF DEATH:

County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Carrie May Mossburg

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Clinton Mossburg

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

May 28, 1877

8. AGE:

Years

Months

Days

If less than one day

71024

hrs.

min.

9. Birthplace

Frederick Co.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

John Talbott

13. Birthplace

Montg. Co.

MOTHER

14. Maiden name

Sarah Frances Walter

15. Birthplace

Frederick Co.

16. Informant

Wm. L. Seymour

Address

7719 Eastern Ave. Lakoma Park

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

6 25 48
(month) (day) (year)

Cemetery or crematory

Manassas

Location

Beallville Md.

18. Funeral director

Wm. B. Hilton

Address

Barnesville, Md.

19.

June 24, 19 48Mrs. C. C. Hilton

Date rec'd by registrar

By Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 19 48, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1947 to June 1948and that I last saw him alive on June 22, 1948

Immediate cause of death

Coronary occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Frank J. Brumhart M.D.
Dr. med. exam. M. D. or other
Address Yarborough Date signed 6/23/48

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age especially important. Physicians; please write the causes of death clearly and legibly.

RECEIVED

JUL '1 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
City or town... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 5 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 month, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Md. County... P. Geo
City or town... Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6012 Inwood Street
(If rural, give LOCATION)
2.(a) If veteran, name war... WWI

3. (a) FULL NAME

Patrick Bernard MULKERN

3. (b) Social Security Number

4. Sex Male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced divorced

6. (b) Name of husband or wife Lucy Mulkern

7. Birth date of deceased (mo., day, yr.) January 23, 1897 6. (c) If alive, give age... years

8. AGE: Years 51 Months 5 Days 3 If less than one day... hrs. ... min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual occupation Publisher

11. Industry or business

12. Name MULKERN, Coleman dec. Ireland

13. Birthplace Ireland

14. Maiden name McDonough, Sara dec. Ireland

15. Birthplace Ireland

16. Informant brother: Mr. Thomas J. McDonough
Address 6012 Inwood St., Cheverly, Md.

17. burial Date thereof 6-29-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. CHAMBERS
Address Hyattsville, Maryland

19. 6-26 19 48 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 June 19 48 at 5:27 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 May 19 48 to 26 June 19 48 and that I last saw him alive on 26 June 19 48

Immediate cause of death Bronchopneumonia, all lobes DURATION 2 days

Due to Cirrhosis of liver yrs.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. R. Cooper, Lt. MC USN M. D. or other

Address USNH Bethesda, Md. Date signed 6-26-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1948

BUREAU V. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: **Montgomery**
County.....
Bethesda (rural)
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **3 months, 21 days**
Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, Bethesda, Md.
How long in hospital or institution? **3 months, 21 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... **Md.** County.....
City or town..... **Hyattsville,**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **3920 Livingston Road**
(If rural, give LOCATION)
2.(a) If veteran, name war **Ex Marine Corps** ✓

3. (a) FULL NAME

MULNIX, Cecil Raymond, Jr.

3. (b) Social Security Number

4. Sex **Male** 5. Color or race **W-US** 6.(a) Single, married, widowed, or divorced **married**
6.(b) Name of husband or wife..... **Shirley Mulnix**
7. Birth date of deceased (mo., day, yr.) **January 24, 1925** 6.(c) If alive, give age..... years
8. AGE: Years **23** Months **4** Days **21** If less than one day
..... hrs. min.

9. Birthplace..... **Maryland**
(Town, county, and state)
10. Usual occupation..... **Ex Marine Corps**
11. Industry or business.....
12. Name..... **MULNIX, Cecil Raymond Sr.**
13. Birthplace..... **W.Va.**
14. Maiden name..... **HESSLER, Anna**
15. Birthplace..... **Maryland**

16. Informant..... **wife: Mrs. Shirley Mulnix**
Address..... **3920 Livingston Road, Hyattsville, Md.**
17. **burial** Date thereof..... **6-18-48**
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... **Arlington National**
Location..... **Arlington, Virginia**
18. Funeral director..... **W. W. CHAMBERS** **J.P.B.**
Address..... **5801 Cleveland Avenue, Biverdale, Md.**
Mary C. Patterson
19. **6-16** **48** **Mary C. Patterson**
(Date rec'd by registrar) Registrar

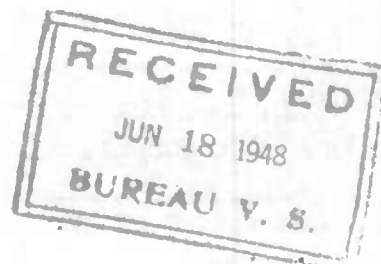
MEDICAL CERTIFICATION

20. DATE OF DEATH..... **15 June** 19 **48** at **3:10 P.M.**
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
24 February 19 **48** to **15 June** 19 **48**
and that I last saw him alive on **15 June** 19 **48**

Immediate cause of death.....
Edema, marked, of epiglottis and larynx
DURATION
2 yrs.
Due to..... **Carcinoma of naso pharynx with metastases to cervical lymph nodes**
Due to.....
Other conditions..... **Anemia, normocytic hypochromic; Pulmonary edema, mild; Cachexia, marked**
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.
Autopsy results..... **confirmed above**
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide..... Date of ..
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?
23. SIGNATURE..... **A.J. DELANEY, Capt. MC USN**
USNH Bethesda, Md. Date signed **6-16-48**



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6364

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
City or town Rural - Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Rural - Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. Wheaton
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

William Wallace Nairn

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Frances Hoerr Nairn

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1865 6.(c) If alive, give age years

8. AGE: Years 82 Months 6 Days 17 If less than one day hrs. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Joseph S. Nairn
13. Birthplace Washington, D. C. ?

14. Maiden name Alice Finckel
15. Birthplace

16. Informant W. W. Nairn Jr.
Address R. F. D. #1 Silver Spring, Md.

17. Cremation Date thereof June 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill
Location Suitland, Prince George Co., Md.

18. Funeral director Waxmex E. Pumphrey, Inc.
Address 8434 Ga. Ave., Silver Spring, Md.

19. June 3 19 48 Joseph W. Schoeffel
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1948 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23, 1948 to June 2, 1948 and that I last saw him alive on May 22, 1948

Immediate cause of death

Cerebral Hemorrhage DURATION Sudden

Due to

Due to

Other conditions Arterio Sclerotic Heart Disease
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

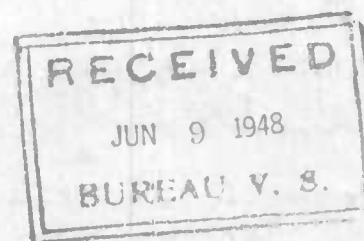
23. SIGNATURE Marion Boushield MD M. D. or other

Address 9601 Sutton place Silver Spring, Md Date signed 6/2/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery CoCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 hrs.

Hospital, institution, or street address where death occurred:

Brooker Rd.

How long is hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. Brooker Rd.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

NEELSON - INFANT FEMALE

3. (b) Social Security Number

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

6-9-48

8. AGE:

Years

Months

Days

If less than one day

4 hrs. 12 min.

9. Birthplace

Silver Spring, Montgomery Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. June 10, 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-9-48 19 at 8:20 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-9-48 to 6-9-48and that I last saw her alive on 6-9-48

Immediate cause of death

Pneumonia 4 3/4
months

DURATION

4 hrs. 5-12
min.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Silver Spring, Md. Date signed 6-10-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

NOTATION

RECEIVED

JUN 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County MontgomeryCity or town RFD Brookeville - "Loonstville"
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 wks

Hospital, institution, or street address where death occurred:

Home of George Sam HowardHow long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County —City or town Baltimore - 23
(If outside city or town limits, write RURAL and give nearest town)Street No. 330 Carrollton Ave.
(If rural, give LOCATION)2.(a) If veteran, name war —

3. (a) FULL NAME

Maria Cora Nettles

3. (b) Social Security Number

4. Sex F 5. Color or race Col 6.(a) Single, married, widowed, or divorced Single6.(b) Name of husband or wife —6.(c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) Sept 24, 18678. AGE: Years 80 Months 8 Days 23 If less than one day — hrs. — min.9. Birthplace Howard, Md.
(Town, county, and state)10. Usual occupation Retired11. Industry or business —12. Name George Nettles13. Birthplace Highland, Howard Co. Md.14. Maiden name Sarah15. Birthplace Sandy Spring Montg Co Md.16. Informant Mrs Laura Howard.
Address Brookeville RFD, Md.17. Burial Date thereof June 25, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Brown ChapelLocation Danbury, Md.18. Funeral director Robert R. Snowden
Address Rockville, Md.19. 6-22 19 48 Bertrude B Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 19 48 at 6:20 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/16/48 19 48 to 6/21 19 48 and that I last saw him alive on 6/21 19 48Immediate cause of death Cardio-vascular accident

DURATION

5 daysDue to Cardiovascular
Due to SenilityOther conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of injury —Injured at work? —23. SIGNATURE W. H. Ligon MD

M. D. or other

Address Sandy Spring, Md Date signed 6/22/48

RECEIVED

JUN 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... **Montgomery**
 City or town..... **Bethesda (rural)**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **5 days**
 Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, Bethesda, Md.
 How long in hospital or institution?..... **5 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... **Washington, D. C.** County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... **1521 Monroe St., N. E.**
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... **WWI**

3. (a) FULL NAME

NOLAND, Homer

3. (b) Social Security Number

4. Sex

Male

5. Color or race

W-US

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mrs. Anna B. Noland

7. Birth date of deceased (mo., day, yr.)

November 27, 1898

6. (c) If alive, give age..... years

8. AGE:

Years

49

Months

7

Days

3

If less than one day

hrs.

min.

9. Birthplace

North Carolina

(Town, county, and state)

10. Usual occupation

Mechanic

11. Industry or business

FATHER

12. Name

NOLAND, Jessie M.

13. Birthplace

N.C.

MOTHER

14. Maiden name

WOODS, Deed

15. Birthplace

N.C.

16. Informant

wife: Mrs. Anna B. Noland

Address

1521 Monroe St., N.E., Washington, D. C.

17.

burial

Date thereof

7-2-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Arlington National

Location

Arlington, Virginia

18. Funeral director

W. W. CHAMBERS

Address

1400 Chapin St., N. W., Wash. D. C.

19.

6-30

19

48

(Date rec'd by registrar)

Registrar**Registrar**

MEDICAL CERTIFICATION

20. DATE OF DEATH

30 June

19

48

at

1:50 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

25 June

19

48

to

30 June

19

48

and that I last saw him alive on

30 June

19

48

Immediate cause of death

Cirrhosis of liver, Hypertrophic

DURATION

indef.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results..... **confirmed above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

USNH Bethesda, Md.Date signed **6-30-48**

RECEIVED

JUL 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6368

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

9928 Brookmoor Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 9928 Brookmoor Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Dorothy C. Norstrom

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

femalewhitewidowed6.(b) Name of husband or wife Victor C. Norstrom

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1894

8. AGE:

Years

Months

Days

If less than one day

54110

hrs.

min.

9. Birthplace Kansas

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name John E. Brennan13. Birthplace Missouri14. Maiden name Rose Perry15. Birthplace Vermont16. Informant Mrs. Madge M. GuarinoAddress 9928 Brookmoor Dr., Silver Spring, Md.17. Removal & burial Date thereof June 9, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Calvary CemeteryLocation Kansas City, Jackson Co., Mo.18. Funeral director Warner E. Pumphrey, Inc.Address 8434 Georgia Ave., Silver Spring, Md.19. June 9 1948 Josephine A. Schaeffe
(Date rec'd by registrar) Registrar23. SIGNATURE Frank J. Broun M. D. or otherAddress Washington, Md. Date signed 6-9-48

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1948 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def. med. exam to 19
and that I last saw h. alive on 19

Immediate cause of death

DURATION

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

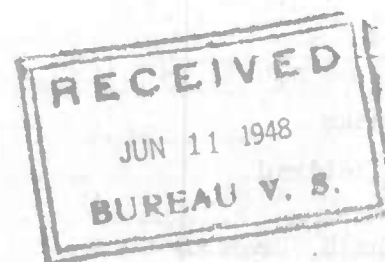
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Broun M. D. or otherAddress Washington, Md. Date signed 6-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: Montgomery
 County.....
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 days
 Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, Bethesda, Md.
 How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Ill. County.....
 City or town Chicago
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5731 N. Sacramento Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME
OWENS, Thomas Leonard, Congressman

3.(b) Social Security Number

4. Sex Male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Emma Owens
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) December 21, 1897
 8. AGE: Years 50 Months 5 Days 16 If less than one day..... hrs. min.

9. Birthplace Ill.
 (Town, county, and state)
 10. Usual occupation Congressman
 11. Industry or business
 12. Name OWENS, John dec
 13. Birthplace Ill.
 14. Maiden name BURKE, Hanna
 15. Birthplace Ill.

16. Informant wife: Mrs. Emma Owens
 Address 5731 N. Sacramento Avenue, Chicago, Ill.
 17. burial Removal Date thereof June 7, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory All Saints
 Location Chicago, Ill.

18. Funeral director Lee Funeral Home
 Address 4th & Mass., Ave., N.E., Wash., D.C.
 19. 6-7- 48
 (Date rec'd by registrar) Registrar Mary C. Patterson

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 June 19 48 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
23 May 19 48 to 7 June 19 48
 and that I last saw him alive on 7 June 19 48

Immediate cause of death Bronchopneumonia DURATION 7 days

Due to Congestive Heart Failure 14 days

Due to Thrombosis Coronary 15 days

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury A. E. Marland, Jr. Injured at work?

23. SIGNATURE A. E. MARLAND, Jr., Lt. JG MC USN

M. D. or other

Address USNH Bethesda, Md. Date signed 6-7-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6369

RECEIVED

JUN 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for correction

of age shown on:

HLM No. G 11 JUN 23 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Kensington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

9 Fawcett St. KensingtonHow long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Kensington
(If outside city or town limits, write RURAL and give nearest town)Street No. 9 Fawcett Street
(If rural, give LOCATION)2.(a) If veteran, name war None

3.(a) FULL NAME

Mrs. Mary A. PREVAIL

3.(b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed

8.(b) Name of husband or wife William J. Prevail-dec.6.(c) If alive, give age dec. years7. Birth date of deceased (mo., day, yr.) June 27, 18818. AGE: Years Months Days If less than one day
17 6 11 14 hrs. min.9. Birthplace Philadelphia, Pennsylvania
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name Hugh F. McQuard13. Birthplace Philadelphia, Pennsylvania14. Maiden name Cathernie O'Malley15. Birthplace Unknown-Pennsylvania18. Informant Mrs. Helen HughesAddress Kensington, Maryland17. Burial June 14, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Forest Glen Church CemeteryLocation Forest Glen, Maryland18. Funeral director Wm. R. RansomAddress Bethesda, Maryland19. 6/14 19 48 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/11/48 19 48 at 7:15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 July 19 June 11/48 19and that I last saw alive on June 10/48 19Immediate cause of death Cardiac Failure

DURATION

4 weeksDue to Arteriosclerosisyear

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Allen M

M. D. or other

Address Christina M Date signed 6/11/48

RECEIVED

JUN 16 1948

BUREAU V. S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

6371

1. PLACE OF DEATH

County Montgomery Registration Dist. No. 223
 Village or City Takoma Park No. #11 Philadelphia Ave St. Ward
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred 1 yrs. 13 mos. 47 ds. How long in U.S. if of foreign birth? 47 yrs. 13 mos. 47 ds.

2. FULL NAME Johanna Bauer Powers Rasehorn

(a) Residence: No. 156 Herman St. Ward San Francisco, Calif. ✓
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (write the word) Married

5e. If married, widowed, or divorced husband
 (or) WIFE of Charles Rasehorn

6. DATE OF BIRTH (month, day, and year) 1-19-79

7. AGE Years 69 Months 5 Days 5 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Home-dressmaker
 9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. at home
 10. Date deceased last worked at this occupation 3 1/2 years ago
 11. Total time (years) spent in this occupation 30

12. BIRTHPLACE (city or town) Visselhevede, Germany
 (State or country)

13. NAME Henry Carstens

14. BIRTHPLACE (city or town) Germany
 (State or country)

15. MAIDEN NAME Wilhelmina Carstens

16. BIRTHPLACE (city or town) Germany
 (State or country)

17. INFORMANT David F. Bauer
 (Address) 4240 15 St. No. Arlington, Va.

18. BURIAL, CREMATION, OR REMOVAL
 Place St. Luke's Am Date June 26, 1948

19. UNDERTAKER Deal's Funeral Home
 (Address) 4812 So. Ave. N.W.

20. FILED June 24, 1948
St. Luke's Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

June 24 1948
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to 6-24, 1948

I last saw her alive on 6-24, 1948; death is said to have occurred on the date stated above, at 4:25 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Rt. broncho-pneumonia Data of onset 6-21-48
Diabetes Mellitis 1932
Generalized Arteriosclerosis 1935

Other Contributory Causes of Importance: Aug.
Diabetic Ulcers and terminal 1946
gangrene both lower extremities.

Name of operation none Date of _____
 What test confirmed diagnosis? lab. & obs. Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of Injury _____, 19____

Where did injury occur? _____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of Injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify No. 1005 Washington Drive, M. D.

(Signed) St. Luke's

(Address) St. Luke's

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>5 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

RECEIVED

JUN 26 1948

BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6372

Reg. Dist. No. 714

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

8707 Georgia Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 8707 Georgia Avenue
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

Ralph A.

3. (b) Social Security Number

214-03-8254

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Anna E. Renner

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1901

8. AGE:

46 Years8 Months12 Days

It less than one day

hrs.min.8. Birthplace New Midway, Maryland
(Town, county, and state)10. Usual occupation Stationary Engineer - National11. Industry or business Dyers & Cleaners Association

MOTHER FATHER

12. Name Elmer A. Renner13. Birthplace New Midway, Md.14. Maiden name Rosie E. Cline15. Birthplace Mt. Airy, Md.16. Informant Mrs. Anna E. RennerAddress 8707 Georgia Ave., Silver Spring, Md.17. Burial Date thereof July 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Church of the Brethren CemeteryLocation Rocky Ridge, Maryland18. Funeral director Wm. E. Humphrey, Inc.Address 8434 Ga. Ave., Silver Spring, Md.19. July 1 19 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 19 48 at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1948 19 48 to June 29, 1948 19 48
and that I last saw h. Sept. 1948 alive on June 29, 1948 19 48

Immediate cause of death

Coronary occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Broschart M.D.
Sept. 1948 M. D. or other
Address Springfield, Md. Date signed 6/29/48

RECEIVED

JUL 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6373

157e

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 618 Bonfant St
(If rural, give LOCATION)

21.(a) If veteran, name war

3. (a) FULL NAME

Ethel Naomi Rich

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Arthur Rich

7. Birth date of

deceased (mo., day, yr.) July 16, 1904

8. (c) If alive, give age _____ years

8. AGE:

Years 43

Months

Days

If less than one day

hrs. min.

9. Birthplace Washington DC
(Town, county and state)10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Richard W. Tucker13. Birthplace Wash. DC

MOTHER

14. Maiden name Sam Ann Popkin15. Birthplace Wash. DC16. Informant Arthur RichAddress 618 Bonfant St.17. Cedar Hill(Burial, cremation, or removal, which?) BurialDate thereof June 29, 1948

(month) (day) (year)

Cemetery or crematory Shutland Ind.Location Cedar Hill18. Funeral director Real Funeral HomeAddress 4812 Ga Ave NW19. June 27

(Date rec'd by registrar)

19. 48Josephine M. Schoeff

Regist.

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 JUNE 19 48 at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JAN. 19 47 to 27 JUNE 19 48and that I last saw h.s. alive on 27 JUNE 19 48Immediate cause of death CONGESTIVE
HEART FAILURE

DURATION

Due to CONGENITAL DEFORMITY OF HEART

Due to

Other conditions NONE

(Include pregnancy within 3 months of death)

Major findings of operations NONEDate of op. NONEAutopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE L. Marshall Lencillier Jr.

M. D. or other

Address 8648 GEORGIA AVE. Date signed 27 JUN. 48SILVER SPRING, MD.

MAINT AND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Handwritten notes:
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RECEIVED
JUL 1 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 7 months, 1 wk.
Hospital, institution, or street address where death occurred:
814 Greenwood Avenue
Apt. # 3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 814 Greenwood Ave.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Mrs. Bertha May Riegel

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Frank McKinley Riegel 6. (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1898

8. AGE: Years 49 Months 9 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Rooring Creek Twnshp. Columbia County, Pa. (Town, county, and state)

10. Usual occupation House wife

11. Industry or business Home

12. Name George Bittner

13. Birthplace Columbia County, Pa.

14. Maiden name Annie Elizabeth Hower

15. Birthplace Columbia County, Pa.

16. Informant Mr. Frank M. Riegel

Address 814 Greenwood Ave. Tak. Park Md.

17. Burial Date thereof June 12, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Catawissa, Penna.

18. Funeral director J. Arthur Walters

Address 254 Carver St. N. Takoma Park, Md.

19. June 9, 1948 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9th 1948 at 7:32 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18, 1948 to June 9th 1948 and that I last saw him alive on June 9th 1948

Immediate cause of death Hypertensive Cardiovascular disease DURATION 15 yrs.

Due to Cerebral Apoplexy Half hour

Due to Acute indigestion 6 hrs.

Other conditions Left hemiplegia 10 1/2 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wallace N. Mook M.D. M. D. or other _____

Address Takoma Park Md. Date signed 6-9-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age is shown on:

FILM No. G 116 JUN 18 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County MONTGOMERY
City or town TAKOMA PARK
(if outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 YEARS
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY
City or town TAKOMA PARK
(if outside city or town limits, write RURAL and give nearest town)
Street No. 405 GREENWOOD AVE
(if rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARGARET RILEY

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife John F. Riley
7. Birth date of deceased (mo., day, yr.) October 31, 1862 6.(c) If alive, give age _____ years
8. AGE: Years 85 Months 7 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace County Cork Ireland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name John Sullivan
13. Birthplace Ireland County Cork
14. Maiden name Catherine Keihane
15. Birthplace County Cork Ireland

16. Informant MRS MARGARET B. Collins
Address 426 - Kentucky Ave S.E
Washington D.C. 6 4 1948

17. BURIAL Date thereof 6 4 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Pennsylvania Ave SE

18. Funeral director Timothy Hanlon

Address 3831- Georgia Ave NW

19. June-7 19 48
(Date rec'd by registrar) Registrar John D. Doherty

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 7 19 48 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 30 19 48, to JUNE 6 19 48

and that I last saw her alive on JUNE 6 19 48

Immediate cause of death HEART FAILURE

DURATION

Due to GENERAL DEBILITY - OLD AGE

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George N. Smith MD M. D. or other

Address 9514 Cokesville Road Date signed 6-7-48
Silver Spring, Md

ARTES-11-10-1948

RECEIVED

JUN 12 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 222

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 yrs.
 Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
 How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 217 Holly Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Janet Elizabeth Roach

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) October 17, 1937 6. (c) If alive, give age..... years

8. AGE: Years 10 yrs Months 8 Days 5 If less than one day..... hrs. min.

9. Birthplace Takoma Park, Md.
 (Town, county, and state)

10. Usual occupation student

11. Industry or business

12. Name H. E. Roach13. Birthplace Portsmouth, Va.14. Maiden name E. Ellen Tallent15. Birthplace Fernwood, N.Y.16. Informant Chart

Address

17. Burial Date thereof Sept. 25, 1948
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Wells CemeteryLocation Fernwood, New York

18. Funeral director Walters Funeral Home
 Address Takoma Park, D.C. 254 Campbell St. NW.

19. June 22, 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22, 1948 at 1:04 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13, 1948 to June 22, 1948
 and that I last saw him alive on June 21, 1948

Immediate cause of death Bronchopneumonia
both lower lobes & right
middle lobe
Moderate bacterial infection
Due to Rheumatic Fever

DURATION

3 wks1 wk

Other conditions

(Include pregnancy within 3 months of death)

Major findings at autopsies

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. V. K. Meade, M.D.Address Takoma Park, Md. Date signed 6-22-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
 County... Montgomery
 City or town... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Ill. County...
 City or town... Cicero
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4920 W. 30th Place
 (If rural, give LOCATION)
 2. (a) If veteran, name war... Marine Corps

3. (a) FULL NAME
ROGACKI, Robert Anthony

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 12, 1929
 8. AGE: Years 18 Months 10 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Illinois
 (Town, county, and state)
 10. Usual occupation Marine Corps
 11. Industry or business

FATHER 12. Name ROGACKI, Anthony dec.
 13. Birthplace Ill.
 MOTHER 14. Maiden name SIENKIEWICZ, Wanda
 15. Birthplace Ill.

16. Informant Mother: Mrs. Wanda Kalus
 Address 4920 W. 30th Place, Cicero, Ill.

17. Burial Date thereof _____ (month) (day) (year)
 (Burial, cremation, or removal. Which?)
 Cemetery or crematory Resurrection Cemetery
 Location Cook County, Illinois

18. Funeral director W. W. Chambers Funeral Home
 Address 1400 Chapin St. N.W., Washington, D. C.

19. 6-5 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1948 at 9:20 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept med exam case 1948 to 1948
 and that I last saw him alive on 1948

Immediate cause of death Hemia
pneumonia, 4th
 Due to injury in auto
accident
 Due to
 Other conditions Rites - functional
hemorrhage
 (Include pregnancy within 8 months of death)
 Major findings at operations
 Date of op.
 Autopsy results same as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide accident Date of 5/29/48
 Where did injury occur? ? Prince Georges, Md
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) highway
 Means of injury auto accident Injured at work? no

23. SIGNATURE Frank J. Bronhart M.D.
Def med exam M. D. or other
 Address Yakobusburg Md Date signed 6/5/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 8 1948

BUREAU V. S.

Reg. Diat. No. 216

6378

93d

1. PLACE OF DEATH:

County.....**Montgomery**.....
City or town.....**Bethesda (mural)**.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....**1 day**.....
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution?.....**1 day**.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....

City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2304 Nicholson St. S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war. WWI ✓

3. (a) FULL NAME

ROGERS, Howard

3. (b) Social Security Number

4. Sex male	5. Color or race W-US	6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife.....Martha Ann Rogers.....		
6.(c) If alive, give age..... years		
7. Birth date of deceased (mo., day, yr.) October 10, 1881		
8. AGE: Years 66	Months 8	Days 9
If less than one dayhrs.min.		

9. Birthplace..... Virginia
(Town, county, and state)

10. Usual occupation..... Retired Civil Service

11. Industry or business.....

FATHER

12. Name..... ROGERS, Howard dec.

13. Birthplace..... Va.

MOTHER

14. Maiden name..... JONES, Annie dec.

15. Birthplace..... Va.

18. Informant wife: Mrs. Martha A. Rogers
Address 2304 Nicholson St., S.E., Wash., D.C.
17. burial Date thereof 6-22-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Arlington National
Arlington, Va.
Location _____
18. Funeral director W.W. Chambers RW
Address 517 11th St S.E. Washington, D.C.
Mary C. Patterson
19. 6-19 48 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19 June 19 48 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 June 19 48 to 19 June 19 48
and that I last saw him alive on 19 June 19 48

Immediate cause of death	DURATION
Pneumonia, Broncho arteriosclerotic Heart Disease	self self
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results: Bronchopneumonia, arteriosclerotic H. D.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Robert L. FIECK

23. SIGNATURE..... Lt. MC USN M. D. or other

Address: USNH Bethesda, Md. Date signed 6-19-49

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 24 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 94a

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 5801 Wilson Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Mary F. Rogers

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Halsey D. Rogers

7. Birth date of

deceased (mo., day, yr.) Feb - 22, 1886 -

8. AGE:

Years

Months

Days

If less than one day

62317

hrs.

min.

9. Birthplace

Harrisonburg, Virginia
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Paul Funkhauser

MOTHER

13. Birthplace

Rockingham Co. Va

14. Maiden name

Minerva King

15. Birthplace

Ohio

16. Informant

H. D. Rogers -

Address

17.

Burial
(Burial, cremation, or removal, Which?)Date thereof June 10, 1948
(month) (day) (year)

Cemetery or crematory

Rock Creek

Location

Washington, D.C.

18. Funeral director

Wm E Humphrey, Inc

Address

8434 Ga. Ave., Silver Spring, Md.

19.

6/11 19 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 8, 1948 at 6:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1947 to June 8, 1948and that I last saw him alive on June 8, 1948

Immediate cause of death

Coronary Thrombosis

DURATION

2 days

Due to

Coronary Arteriosclerosis

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Paul Blanton MD
M. D. or otherAddress Bethesda Md Date signed 6/9/48

RECEIVED

JUN 12 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

6380
216

1. PLACE OF DEATH: **Montgomery**
County.....
City or town..... **Bethesda (rural)**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **1 day, 8 hrs.**
Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, Bethesda, Md.
How long in hospital or institution? **1 day, 8 hrs.**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... **Washington, D. C.** County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No. **1333 U St., S.E.**
(If rural, give LOCATION)
2.(a) If veteran, name war..... **SpAm War**

3.(a) FULL NAME
ROSE, Oscar Leonadus

3.(b) Social Security Number

4. Sex **Male** 5. Color or race **W-US** 6.(a) Single, married, widowed, or divorced **married**
6.(b) Name of husband or wife **Agnes V. Rose**
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) **January 15, 1877**
8. AGE: Years **71** Months **5** Days **13** If less than one day hrs. min.

9. Birthplace..... **Tenn.**
(Town, county, and state)
10. Usual occupation..... **retired fireman**
11. Industry or business

12. Name **ROSE, Wine,** dec.
13. Birthplace **unknown**
14. Maiden name **unknown**
15. Birthplace **unknown**

16. Informant **Wife: Mrs. Agnes V. Rose**
Address **1333 U St., S.E., Wash., D.C.**
17. **burial** Date thereof **7-1-48**
(Burial, cremation, or removal, which?) (month) (day) (year)
Arlington National Cemetery
Cemetery or crematory.....
Location **Arlington, Va.**

18. Funeral director **Simmons Brothers**
Address **2007 Nicholas Ave. S.E. Washington, D.C.**
Mary C. Patterson
6-29-48 19. **148**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **28 June** 19 **48**, at **8:35 P.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **27 June** 19 **48**, to **28 June** 19 **48**, and that I last saw him alive on **28 June** 19 **48**.

Immediate cause of death.....
HYPERTENSIVE-HEART-DISEASE
Due to **HYPERTENSION**
Due to **ARTERIOSCLEROSIS**
Other conditions **CEREBRAL-THROMBOSIS**
DIABETES
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE..... **Charles Savage**
Charles Savage
Address **USNH Bethesda, Md.** Date signed **6-29-48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 218

6381

1. PLACE OF DEATH:

County Montgomery Co.
 City or town Clarksburg, Md. (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Clarksburg, Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Annie Rebecca Runion

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife David Franklin Runion
 6.(c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Sept 17th 1868

8. AGE: Years 79 Months 9 Days 12 If less than one day
1868 hrs. _____ min.

9. Birthplace Rockingham Co., Va.
 (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business _____

FATHER 12. Name William Bexter
 13. Birthplace Va.

MOTHER 14. Maiden name Sallie Walters
 15. Birthplace Va.

16. Informant Minnie Whetzel
 Address Clarksburg Md.

17. Burial Date thereof July 2, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Hyattstown Cemetery
 Location Hyattstown Md.

18. Funeral director Ernest C Gartner
 Address Gaithersburg Md.

19. July 2 19 48 Albunda L. Cook
 Date read by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1948 at 3:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18, 1948 to June 29, 1948
 and that I last saw her alive on May 18, 1948

Immediate cause of death arteriosclerotic cardiac
vascular disease

and thymoplegia

Due to _____

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

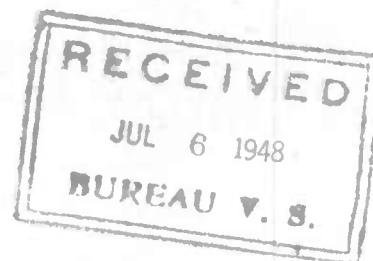
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Mens of injury _____ Injured at work? _____

23. SIGNATURE James P. Kerr M.D.
 _____ M. D. or other
 Address Clarksburg, Md. Date signed 6/30/48



RECEIVED

JUL 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

6382

Reg. Dist. No. 223

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

805 Maple Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County WashingtonCity or town Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3630 South Dakota Ave N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARY J. RYAN

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

JOHN A. RYAN

7. Birth date of deceased (mo., day, yr.)

Nov. 11, 1874

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

83

hrs. min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name

James T. Humphrey

13. Birthplace

Va.

14. Maiden name

Zitter

15. Birthplace

Va.

16. Informant

John A. Ryan

Address

3630 South Dakota Ave N.E.

17. (Burial, cremation, or removal. Which?) Date thereof

Buried

July 29, 1948

(month) (day) (year)

Cemetery or crematory

Fort Lincoln Cemetery

Location

Prince Georges County, Md.

18. Funeral director

W. Warren Tatum

Address

3619 18th St. N.W.

19. (Date rec'd by registrar)

June 29, 48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 29, 1948

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw him alive on

June 29, 1948

Immediate cause of death

Coronary thrombosis

Myocardial infarction

DUE TO

DUE TO

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Address

Date signed

RECEIVED

JUL 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

6383

Y14

1. PLACE OF DEATH:

County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs
 Hospital, institution, or street address where death occurred:
8010 Eastern Drive
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 8010 Eastern Drive
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Louis T. Shepherd
 4. Sex Male 5. Color or race W 6.(a) Single, married, widowed, or divorced married

3. (b) Social Security Number

420-18-7207

6.(b) Name of husband or wife

Eucile Shepherd

7. Birth date of deceased (mo., day, yr.) July 13 1904
 6.(c) If alive, give age 31 years

8. AGE: Years 43 Months 10 Days 23 If less than one day
 hrs. min.

9. Birthplace Oakman Ala.
 (Town, county, and state)

10. Usual occupation accountant

11. Industry or business

12. Name Louis T. Shepherd

13. Birthplace Ala.

14. Maiden name Bethana Hassell

15. Birthplace Ala.

16. Informant Louis T. Shepherd

Address 8010 Eastern Dr Silver Spring Md

17. Burial Date thereof June 9 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Jasper Alabama

Location Jasper Alabama

18. Funeral director W. Reuben Thompson

Address Bethesda, Maryland

19. June 7 1948 Jasper W. Sheaffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1948 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1947 to 1948

and that I last saw him alive on Sept. 1948

Immediate cause of death

Coronary occlusion

Due to

Coronary occlusion

Due to

Coronary occlusion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Frank J. Brochant M.D.

23. SIGNATURE Dr. J. W. Sheaffer M. D. or other

Address Yantheusburg Md Date signed 6/6/48

RECEIVED
JUN 10 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6384

216

Reg. Dist. No.

1. PLACE OF DEATH: **Montgomery**
 County.....
 City or town..... **Bethesda (rural)**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **2 hours**
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? **2 hours**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **W.Va.** County.....
 City or town..... **New Huntington**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **1307 Arlington Terrace**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME **SMITH, Baby Boy** 3. (b) Social Security Number

4. Sex **Male** 5. Color or race **W-US** 6.(a) Single, married, widowed, or divorced **single**
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) **15 June 1948**
 8. AGE: Years Months Days If less than one day
2 hrs. min.

9. Birthplace **Bethesda, Md.**
 (Town, county, and state)
 10. Usual occupation.....
 11. Industry or business.....
 12. Name **SMITH, "J" "C"**
 13. Birthplace **Texas**
 14. Maiden name **WARE, Margaret Marie**
 15. Birthplace **Washington, D. C.**

16. Informant **father: Sgt. "J" "C" SMITH, USMC**
 Address **HS Company, Marine Hdqtrs., Henderson Hall, Wash. D.C.**
 17. **burial** Date thereof **6-16-48**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory **Arlington National**
Arlington, Va.
 Location.....
 18. Funeral director **W. W. CHAMBERS** **R.M.G.**
 Address **1400 Chapin St., N. W., Wash. D.C.**
Mary C. Patterson
6-15- 19 **48** **Mary C. Patterson**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **15 June** 19 **48**, at **10:40 AM**
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **15 June** 19 **48**, to **15 June** 19 **48**,
 and that I last saw him alive on **15 June** 19 **48**,
 Immediate cause of death **Prematurity 6 1/2 months** DURATION

Due to **severe hepatic toxemia of the mother**
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)
 Major findings of operations..... Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE **PAUL PETERSON, Capt. (MC), USN** M.D. or other
USNH Bethesda, Md.
 Address..... Date signed **6-15-48**

RECEIVED

JUN 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County.....Montgomery
 City or town.....Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....1 month, 9 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution?.....1 month, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Virginia County.....
 City or town.....New Huntington,
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....1307 Arlington Terrace
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

SMITH, Margaret Marie

3. (b) Social Security Number

4. Sex.....Female 5. Color or race.....White-US 6.(a) Single, married, widowed, or divorced.....Married
 6.(b) Name of husband or wife.....Sgt. J. C. Smith USMC
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....April 4, 1919
 8. AGE: Years.....29 Months.....2 Days.....16 If less than one day..... hrs. min.

9. Birthplace.....Washington, D. C.
 (Town, county, and state)
 10. Usual occupation.....housewife
 11. Industry or business.....

FATHER 12. Name.....WARE, William
 13. Birthplace.....Va.
 MOTHER 14. Maiden name.....JOHNSON, Maude
 15. Birthplace.....Va.

16. Informant.....husband: Sgt. J. C. Smith
 Address.....1307 Arlington Terrace, Alexandria, Va.
 17. burial Date thereof.....6-23-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....Arlington National
 Location.....Arlington, Virginia

18. Funeral director.....W.W. CHAMBERS
 Address.....1400 Chapin St., N.W., Washington, DC

19. 6-20- 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....20 June 19 48 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
11 May 19 48 to 20 June 19 48
 and that I last saw him alive on 20 June 19 48

Immediate cause of death.....Toxemia of pregnancy
 DURATION.....
 Due to.....nephritic type
hypertension
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....Same kidney condition as seen
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE.....PAUL PETERSON, Captain MC USN
 M. D. or other
 Address.....USNH Bethesda, Md. Date signed 6-20-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 23 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

95C

6386

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Norbeck
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary E. Snowden

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

John W. Snowden

7. Birth date of deceased (mo., day, yr.)

August 1, 1888

8. (c) If alive, give age 66 years

8. AGE:

59 Years

10 Months

18 Days

If less than one day

hrs.

min.

9. Birthplace

Sandy Spring, Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Fletcher Clock

FATHER

12. Name

and

13. Birthplace

Mary Hill

MOTHER

14. Maiden name

and

15. Birthplace

John W. Snowden

16. Informant

Rockville, Md. R.F.D.

Address

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

June 24, 1948
(month) (day) (year)

Cemetery or crematory

Sandy Spring

Location

Sandy Spring, Md.

18. Funeral director

Robert H. Snowden

Address

Rockville, Md.

19. 6-24
(Date rec'd by registrar)

19 48

Estrode B. Lawler
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Norbeck
(If outside city or town limits, write RURAL and give nearest town)

Street No.

Norwood Road
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 20 19 48 at 8:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 15 19 36 to June 20 19 48

and that I last saw him/her alive on June 20 19 48

Immediate cause of death

Coronary Thrombosis sudden

Due to

Cardiac Hypertrophy

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter Sewell M.D.
Address Norbeck, Md. Date signed 6-22-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Evidence for change of age, name
and birth date shown on:

2411 N. Charles St., Baltimore

131a

6387

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH

County MontgomeryCity or town Baltimore, Md.

Street address, hospital, or institution:

Curtis - Lu. Rest Home - 11 Philadelphia ave.Stay in hospital or inst. (yrs., or mos., or days) 4 months 5 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State _____ County _____

City or town Washington, D. C.

(If outside city or town limits, write RURAL NEAR and give town) Ward No. _____

Street No. 12 T St., N.W.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Mrs. Bessie E. Spalding

(SPALDING)

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

1918 1878

8. AGE:

70

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Lucketts, Va.

(Town, county, and state)

10. Usual occupation

At home

11. Industry or business

FATHER

12. Name

Andrew Coates

13. Birthplace

Lucketts, Va.

MOTHER

14. Maiden name

15. Birthplace

16. Informant

L. Heightman

Address

4022 Ill. Ave., N.W., Wash. D. C.

17.

BurialDate thereof June 21, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

Point of Rocks, Md.

18. Funeral director

Det. Hiner Co

Address

2901 - 14th NW, Wash. D.C.

19.

June 2119 48

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 21 19 48, at 10:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 15 19 47, to June 21 19 48and that I last saw her alive on June 21 19 48

Immediate cause of death

cerebral hemorrhage

DURATION

24 hrs

Due to

arteriosclerosis and hypertension2 yrs

Due to

Other conditions

chronic cardio-vascular renal disease2 yrs

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel B. Washington, M.D.

M. D. or other

Address

6234 La AveDate signed 6/21/48

1
FEDERAL BUREAU OF INVESTIGATION
DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. DATE OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SEX

12. RACE

13. AGE

14. DATE OF BIRTH

15. PLACE OF BIRTH

16. DATE OF DEATH

17. PLACE OF DEATH

18. CAUSE OF DEATH

19. MANNER OF DEATH

20. SEX

21. RACE

22. AGE

23. DATE OF BIRTH

24. PLACE OF BIRTH

25. DATE OF DEATH

26. PLACE OF DEATH

27. CAUSE OF DEATH

28. MANNER OF DEATH

29. SEX

30. RACE

31. AGE

32. DATE OF BIRTH

33. PLACE OF BIRTH

34. DATE OF DEATH

35. PLACE OF DEATH

36. CAUSE OF DEATH

37. MANNER OF DEATH

RECEIVED
JUN 24 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 day
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town Washington,
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2244 Shannon Pl., S.E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

STIDHAM, Mary Ellen

3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 7 June 1948 6.(c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Bethesda, Maryland
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name STIDHAM, Walter Dale13. Birthplace Ky.14. Maiden name KOHLER, Betty15. Birthplace Washington State16. Informant father: Walter Dale Stidham, ADJ USNAddress US Naval Air Station, Anacostia, D.C.

17. burial Date thereof 6-15-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director W. W. CHAMBERSAddress 1400 Chapin St., N. W., Wash., D.C.

19. 6-13 19 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 June 19 48 at 10:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 June 19 48 to 13 June 19 48

and that I last saw him or alive 13 June 19 48

Immediate cause of death Pneumonia DURATION _____

Due to Intrauterine infection

Due to in mother causing asphyxia

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE PAUL PETERSON, Capt. MC USNAddress USNH Bethesda, Md. Date signed 6-13-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 16 1948
BUREAU V. S.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age and birth date shown on:
 FILM NO. G 116 JUL 16 1948 MARYLAND STATE DEPARTMENT OF HEALTH
 2411 N. Charles St., Baltimore

6389

Reg. Dist. No. 316

CERTIFICATE OF DEATH 93d

1. PLACE OF DEATH

County MontgomeryCity or town Cherry Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6310 Oakridge Ave

How long in hospital or institution?

2 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Cherry Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. 6310 Oakridge Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Alice Calrent

3. (b) Social Security Number

Sullivan

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed.6. (b) Name of husband or wife Edward Johnston

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Oct. 9, 1865 1864

8. AGE:

Years

83

Months

7

Days

27

If less than one day

hrs.

min.

9. Birthplace

Alexandria La.

(Town, county, and state)

10. Usual occupation

H - wife.

11. Industry or business

FATHER
MOTHER

12. Name

Tacitos Calrent.

13. Birthplace

La.

14. Maiden name

Vennette A. Wells.

15. Birthplace

La.

16. Informant

Col. Desmond O'Keefe.

Address

6310 Oakridge Ave.

17.

(Burial, cremation, or removal. Which?)

Date thereof

June 9, 1948
(month) (day) (year)

Cemetery or crematory

Pineville Cem.

Location

Alexandria La.

18. Funeral director

W. W. Chambers. Co

Address

3072 - M - N. W. Wash., D. C.

19.

(Date rec'd by registrar)

6/6 1948Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 6, 1948 at 2 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1946 to June 6, 1948and that I last saw him alive on June 5, 1948

Immediate cause of death

Respiratory failure 2 days

Due to

Coronary thrombosis - 2 wks

Due to

Hyperextension - CardiacOther conditions nasal polyps since 1940

(Include pregnancy within 3 months of death)

Major findings of operations

no operation

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. B. Glenn

M. D. or other

Address

2815 Quail

Date signed

6/6/48

RECEIVED

JUN 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

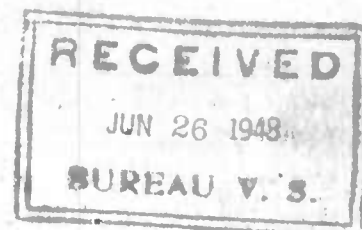
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6390

Reg. Dist. No. 216

1. PLACE OF DEATH: County..... <u>Montgomery</u> City or town..... <u>Bethesda (rural)</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>25 days</u> Hospital, institution, or street address where death occurred: <u>US Naval Hospital, Bethesda, Md.</u> How long in hospital or institution?..... <u>25 days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>D.C.</u> County..... City or town..... <u>Washington</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>3317 15th St., S.E.</u> (If rural, give LOCATION) 2. (a) If veteran, name war..... <u>WWI</u>			
3. (a) FULL NAME <u>THORNTON, Richard Ernest</u>				3. (b) Social Security Number			
4. Sex <u>male</u>				5. Color or race <u>Col.</u>			
6. (a) Single, married, widowed, or divorced <u>married</u>				6. (b) Name of husband or wife <u>Francis M. Thornton</u>			
7. Birth date of deceased (mo., day, yr.) <u>December 26, 1889</u>				8. (c) If alive, give age years			
8. AGE: Years <u>58</u>		Months <u>5</u>		Days <u>28</u>		It less than one day hrs. min.	
9. Birthplace <u>Washington, D. C.</u> (Town, county, and state) <u>Civil Service</u>				10. Usual occupation			
11. Industry or business				12. Name <u>THORNTON, Richard</u> <u>dec.</u>			
13. Birthplace <u>Va.</u>				14. Maiden name <u>Letitia ?</u> <u>dec.</u>			
15. Birthplace <u>Va.</u>				16. Informant <u>WIFE: Mrs. Francis M. Thornton</u> Address <u>3317 15th St., S.E., Wash., D.C.</u> <u>burial</u>			
17. (Burial, cremation, or removal. Which?) <u>burial</u>				Date thereof <u>June 29, 1948</u> (month) (day) (year) Cemetery or crematory <u>Arlington National</u> <u>Arlington, Va.</u> Location			
18. Funeral director <u>McGuire Funeral Home</u> <u>R.M.</u> Address <u>1820 9th St., N. W., Wash., D.C.</u>				19. (Date rec'd by registrar) <u>6-25-</u> <u>19 48</u> <u>Mary C. Patterson</u> <u>Mary C. Patterson</u> Registrar			
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>24 June</u> <u>19 48</u> at <u>6:14 PM</u>							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>29 May</u> <u>19 48</u> to <u>24 June</u> <u>19 48</u> and that I last saw h. <u>im</u> alive on <u>24 June</u> <u>19 48</u>							
Immediate cause of death <u>Chronic Nephritis</u>						DURATION <u>17 yrs.</u>	
Due to <u>Hypertension, Arterial</u>						<u>2 yrs.</u>	
Due to							
Other conditions							
(Include pregnancy within 3 months of death)							
Major findings of operations							
Date of op.							
Autopsy results							
PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, till in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?							
23. SIGNATURE <u>J. T. Jones, Jr.</u> <u>J. T. JONES, Jr., Lt. M.D.</u> Address <u>USNH Bethesda, Md.</u> Date signed <u>6-25-48</u>							



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH

County... Montgomery
 City or town... Takoma Park, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Washington Sanatorium + Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C. County...
 City or town... Washington, D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 518 9th St. N.E.
 (If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Miss Augusta M. Vollmer

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow
 6.(b) Name of husband or wife Herman H. Vollmer
 7. Birth date of deceased (mo., day, yr.) May 11, 1862
 6.(c) If alive, give age... years
 8. AGE: Years 86 Months 1 Days 7 If less than one day... hrs. ... min.

9. Birthplace... Germany
 (Town, county, and state)

10. Usual occupation... none

11. Industry or business

FATHER
 12. Name Karl Kaiser
 13. Birthplace Germany
 MOTHER
 14. Maiden name Mary Beunkow
 15. Birthplace Germany

16. Informant Louisa B. J. Vollmer
 Address 518 9th St. N.E. Wash. D.C.
 17. (Burial, cremation, or removal, Which?) Burial Date thereof June 19, 1948
 (month) (day) (year)

Cemetery or crematory Harmon, S. D.
 Location

18. Funeral director S. H. Hines Co.
 Address 2901-14th St. N.W.

19. June 19 19 48 J. W. Dwyer Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 19 48 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 19 48 to June 18 19 48 and that I last saw him alive on June 18 19 48

Immediate cause of death... Terminal Hemiparesis DURATION 3 days

Due to Cerebral Thrombosis 3 days

Due to Generalized Arteriosclerosis

Other condition

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. J. K. Made M.D. M. D. or other

Address Takoma Park, Md. Date signed 6-18-48

RECEIVED

JUN 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6393

Reg. Dist. No. 216

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 2 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution?..... 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... D.C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1208 3rd St., N. W.
(If rural, give LOCATION)
2. (a) If veteran, name war..... WWI

3. (a) FULL NAME

WANDER, Harry

3. (b) Social Security Number

4. Sex..... male
5. Color or race..... Col
6. (a) Single, married, widowed, or divorced..... married
6. (b) Name of husband or wife..... Louise Wander
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.)..... June 3, 1898
8. AGE: Years..... 50 Months..... 0 Days..... 26
If less than one day..... hrs. min.

9. Birthplace..... Virginia
(Town, county, and state)
10. Usual occupation..... Civil Service
11. Industry or business.....
12. Name..... WANDER, Johnson dec.
13. Birthplace..... Va.
14. Maiden name..... JONES, Ida
15. Birthplace..... Va.

16. Informant..... wife: Mrs. Louise Wander
Address..... 1208 3rd St., N. W. Wash., D.C.
17. burial Date thereof..... 7-6-48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory..... Arlington National
Location..... Arlington, Va.

18. Funeral director..... Jenkins & Johnson
Address..... 2053 Georgia Ave., N. W. Wash., D.C.
Mary C. Patterson
19. 6-29 19 48 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... 29 June 19 48 at 11:40 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
27 June 19 48 to 29 June 19 48
and that I last saw him alive on 29 June 19 48
Immediate cause of death..... Intraspinal injury (C2)
(Fracture of second vertebral body)

DURATION
Due to.....
Due to.....
Other conditions..... Terminal respiratory
Paralysis
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....
Autopsy results..... confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... accident Date of..... 6-26-48
Where did injury occur?..... Washington, D. C.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)..... home
Means of injury..... fell in own home Injured at work?.....
23. SIGNATURE..... JOHN C. McNERNEY, Cdr. MC USNR
M. D. or other
Address..... USNH Bethesda, Md. Date signed..... 6-29-48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

. . . DISTRICT CORONER NOTIFIED AND APPROVED.

RECEIVED

JUL 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County... MontgomeryCity or town... Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

8910 Georgia Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... MontgomeryCity or town... Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 8910 Georgia Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Clarence Ward

3. (b) Social Security Number

214-16-7676

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife... Elizabeth D. Ward

B. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.) Feb. 8, 1874

8. AGE:

Years

Months

Days

If less than one day

74327

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation... Maintenance Man at the Takoma

11. Industry or business

Park Junior High School

FATHER

12. Name

Thomas George Ward

13. Birthplace

Md.

MOTHER

14. Maiden name

Josephine Thompson

15. Birthplace

Md.18. Informant... Mrs. Elizabeth D. WardAddress 8910 Ga. Ave., Silver Spring, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... June 8, 1948
(month) (day) (year)Cemetery or crematory... Forest Oak CemeteryLocation... Gaithersburg, Md.

18. Funeral director

Waxner E. Pumphrey, Inc.Address 8434 Ga. Ave., Silver Spring, Md.19. June 6 19 48
(Date rec'd by registrar)

19

48

Josephine M. Schaeffer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

5 June

19

48 at 4:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 19 47 to 5 June 19 48and that I last saw him alive on 5 June 19 48

Immediate cause of death

Chondrosarcoma of pelvis

DURATION

14-15 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William D. And, M.D.

M. D. or other

Address

Silver Spring Md

Date signed

5 June 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 9 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

6395

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Norbeck
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Montgomery

City or town Norbeck
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John Warfield

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 9, 1878

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

70

hrs.

min.

9. Birthplace

Haward County, Md.
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

Robert Warfield

13. Birthplace

Md.

MOTHER

14. Maiden name

Rachel Reutter

15. Birthplace

Md.

16. Informant

Address

Mrs. Florence Johnson (Daughter)
Norbeck, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

June 11, 1948
(month) (day) (year)

Cemetery or crematorium

Sandy Spring

Location

Sandy Spring, Md.

18. Funeral director

Address

R. A. Spaulding
Rockville, Md.

19.

6-10

19

48

Gertrude B. Lawler

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 8, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 29, 1940 to June 8, 1948

and that I last saw him alive on June 7, 1948

Immediate cause of death

Cardiorenal Disease

DURATION

1940

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter Sewell M.D.

M. D. or other

Address

Norbeck

Date signed

June 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 17 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:

County Montgomery
City or town Damascus Rural Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Damascus Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Richard M Watkins

3. (b) Social Security Number

no

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife _____ 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov 12 - 1944

8. AGE: Years 3 Months 7 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation no

11. Industry or business no

12. Name Wilfred M Watkins

13. Birthplace Maryland

14. Maiden name Pauline King Watkins

15. Birthplace Maryland

16. Informant Wilfred M Watkins

Address Damascus Md

17. Burial Date thereof Jan 17 - 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Damascus Md

Location Montgomery Co Md

18. Funeral director Chas W Barber

Address Ligonville Md

19. June 17 19 48 Lella W Burdett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 June 19 48 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 3 19 47 to 15 June 19 48
and that I last saw him alive on 12 June 19 48

Immediate cause of death Neuroblastoma, probably retroperitoneal primary involving adrenal, both orbits, and long bones

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations Neuroblastoma (biopsy) Date of op. 25 Nov 47

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Chas Raudol M. D. or other MD

Address Damascus Md Date signed 16 June 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 19 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6397

Reg. Diat. No. 212

1. PLACE OF DEATH:

County Montgomery
City or town Boyd's
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 72 years
Hospital, institution, or street address where death occurred: none
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Boyd's
(If outside city or town limits, write RURAL and give nearest town)
Street No. none
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME

William Mc Kendree Williams

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Sarah R Williams
6.(c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) Sept. 14 - 1875
8. AGE: Years 72 Months 8 Days 26 It less than one day hrs. min.

9. Birthplace Boyd's - Montg Co. Maryland
(Town, county, and state)

10. Usual occupation Farmer - Merchant

11. Industry or business none

12. Name James E. Williams

13. Birthplace Boyd's - Maryland

14. Maiden name Sarah Jane Burdette

15. Birthplace unknown

16. Informant Mrs. Bradford N. Hadley

Address Wall St - Rockville - Md

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof June 12 - 1948
(month) (day) (year)

Cemetery or crematory Monocacy Cemetery

Location Brallsville - Montg Co - Maryland

18. Funeral director Wm. Rufus Rumphrey

Address Bethesda - Maryland

19. Date rec'd by registrar 6/12 1948 Mrs. C. C. Hilton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1948 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15, 1948 until June 10, 1948

and that I last saw him alive on June 2, 1948

Immediate cause of death Coronary thrombosis

Other conditions Arteriosclerotic cardiovascular disease

Due to 10 yrs.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James P. Kerr M.D.

Address Hammonds, Md.

Date signed 6/11/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 19 1948

BUREAU V. S.

Evidence for change of
age and birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 116 JUN -9 1948 CERTIFICATE OF DEATH

6398

218

Reg. Dist. No.

1. PLACE OF DEATH: Montgomery
County.....
Bethesda (rural)
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, Bethesda, Md.
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... D.C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1316 W St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war..... WWI

3. (a) FULL NAME
WILLIAMS, David Lawrence

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Mrs. Rachel Williams
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) June 9, 1892 1894
8. AGE: Years 53 55 Months 11 Days 23 22 hrs. min.

9. Birthplace Florida
(Town, county, and state)
10. Usual occupation Gardener
11. Industry or business
12. Name WILLIAMS, James dec.
13. Birthplace Florida
14. Maiden name BUTLER, Fannie dec.
15. Birthplace Washington, D. C.

16. Informant wife: Mrs. Rachel Williams
Address 1316 W St., N. W., Wash., D.C.
17. burial Date thereof 6-1-48
(Burial, cremation, or removal, which?)
Arlington National Cemetery
Cemetery or crematory
Location Arlington, Va.
18. Funeral director W. Ernest Jarvis
Address 1432 U St., N. W., Wash., D.C.
19. 6-1 48 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 June 19 48 at 1:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
23 May 19 48 to 1 June 19 48
and that I last saw him alive on 1 June 19 48

Immediate cause of death Nephritis, Chronic
DURATION indef.

Due to
Due to

Other conditions Hypertension, Arterial indef.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. E. Watters, Jr., LT JG MC USN
M. D. or other
Address USNH Bethesda, Md. Date signed 6-1-48

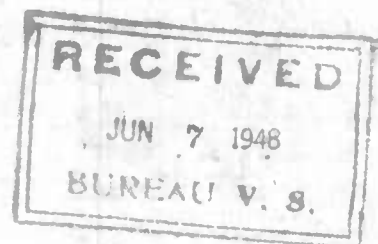
MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7-17-31
1948-X-X
1894-6-9

63-11-22



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The for age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

6399

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
 City or town 2800 Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:
34 Hickory Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery
 City or town Inkoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 34 Hickory Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

HERBERT PEKIN WOODIN

3. (b) Social Security Number

— none

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 4 1866
 6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

81

10

hrs.

min.

9. Birthplace

Pekin, China

(Town, county, and state)

10. Usual occupation

Retired Congregational Minister

11. Industry or business

FATHER

12. Name

Simon F. Woodin

13. Birthplace

Green River New York (N)

MOTHER

14. Maiden name

Sarah Lee Webb

15. Birthplace

Exeter, New Hampshire

16. Informant

Miss Gertrude L. Woodin

Address

34 Hickory Ave. Inkoma Park. Md.

17.

Cremation

Date thereof June 21 1948.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Cedar Hill Cemetery

Location

Perry Ave. S.E. Exeter

18. Funeral director

Arthur Walters

Address

254 Carroll St. Baltimore, Md.

19.

June 21 1948

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1948, at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 1947 to June 21 1948, and that I last saw him alive on June 20 1948.

Immediate cause of death

Carcinoma
 (aplastic features of colon)

DURATION

8 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

O. B. Pitts, M.D.

M. D. or other

Address 6911 S.W. 8th St. NW Date signed June 21/48

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JUN 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:

County Montgomery
 City or town Rural Bgds. Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 48 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Rural Bgds. Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Charles Frank Wright

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Lula A. Wright
 7. Birth date of deceased (mo., day, yr.) April 10 - 1862 6. (c) If alive, give age 87 years
 8. AGE: Years 86 Months 2 Days 0 If less than one day _____ hrs. _____ min.

9. Birthplace Loudon Co. Va.
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Farming
 12. Name Charles Wright
 13. Birthplace Bgds.
 14. Maiden name Catherine Sampson
 15. Birthplace Va.

16. Informant Mrs. Lula A. Wright
 Address Bgds. Md.

17. Buried Date thereof Jan 13 - 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Chalksburg Md.
 Location Montgomery Co. Md.

18. Funeral director Robt. W. Barber
 Address Lyttonville Md.

19. June 12 19 48 Della K. Burdette
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 - 1948 at 5:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15, 1948 to June 10, 1948 and that I last saw him alive on June 10, 1948.

Immediate cause of death Cerebral hemorrhage DURATION 2 days

Due to Arteriosclerotic Cardiovascular disease 25 yrs.

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE James P. Kerr M.D.
 Address Damascus, Md. Date signed 6/11/48

RECEIVED

JUN 15 1948

BUREAU V. S.